FY 2006 Mental Health Block Grant Plan

Submitted by
MaryAnne Lindeblad, Interim Director
Mental Health Division
Department of Social and Health Services
DUNS # 12-734-7115
Olympia, Washington
August 1, 2005

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Mental Health Division
P.O. Box 45320, Olympia, Washington 98504

August 1, 2005

LouEllen M. Rice, Grants Management Officer
Division of Grants Management
OPS, SAMHSA
One Choke Cherry Road
Room 7-1091
Rockville, MD 20857

Dear Ms. Rice:

Enclosed is Washington State's Community Mental Health Services Block Grant application and plan for fiscal year 2006. This plan meets the requirements of Public Law 102-231, has been created with and approved by the Mental Health Planning and Advisory Council, and contains all the required funding agreements, certifications, and assurances necessary to ensure its eligibility for consideration.

If you have any questions, please contact Amy Besel, the designated State Planner. She may be reached at BeselAJ@DSHS.wa.gov or 360-902-0202.

Sincerely,

MaryAnne Lindeblad, Interim Director
Mental Health Division

Enclosure
cc: Amy Besel, State Planner
Joann Freimund, MHPAC Chair

FACE SHEET
FISCAL YEARS COVERED BY THE PLAN
Fiscal years covered by the plan:
__FY 2005-2007 _**X**_ FY 2006 _FY 2007

STATE NAME: Washington State

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Social and Health Service, DUNS # 12-734-7115

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia ZIP CODE: 98504-5320

TELEPHONE: 360-902-0807 FAX: 360-902-0809

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: MaryAnne Lindeblad (or her successor) TITLE: Interim Director

AGENCY: Department of Social and Health Division

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia ZIP CODE: 98504-5320

TELEPHONE: (360) 902-0790 FAX: (360) 902-0809

III. STATE FISCAL YEAR

FROM: July 1, 2006 TO: June 30, 2007

IV. PERSON TO CONTACT WITH ANY QUESTIONS REGARDING THE APPLICATION

NAME: Amy Besel TITLE: Mental Health Program Administrator

AGENCY: Department of Social and Health Services

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia ZIP CODE: 98504-5320

TELEPHONE: (360) 902-0202 FAX: (360) 902-0809

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2006 Community Mental Health Services Block Grant Application

Part A: Executive Summary

The Mental Health Division of the State of Washington herein submits its application and plan for the utilization of Community Mental Health Services Block Grant funding for FFY 2006. This document is essential by design to the well-being and quality of life for the many individuals in our state who carry psychiatric disabilities and for the people who love and care about them. As such, we seek to have this plan serve as tangible hope for a better future by clearly outlining our intentions for continued change and improvement to our community mental health services. This plan meets all of the requirements of application, has been reviewed by community stakeholders, is supported by the state Mental Health Planning and Advisory Council, and is consistent with federal guidelines aimed at achieving the following goals:

- Increasing access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental and health services, along with mental health services and supports;
- Ensuring the participation of consumers and their families in planning and evaluation of state systems;
- Improving access for underserved populations, including homeless people and rural populations;
- Expanding the promotion of recovery and community integration of people with psychiatric disabilities; and
- Delivering accountability through uniform reporting on access, quality, and the outcome of services.

In tandem with the federal guidelines listed above, this document encompasses Washington State's deep rooted commitment to bring to realization the fundamental goals outlined in the July 2003 Final Report of the President's New Freedom Commission on Mental Health entitled, "Achieving the Promise: Transforming Mental Health Care in America".

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family driven.
- Disparities in mental health services are eliminated.
- Early mental health screening, assessment, and referral to services are common practice.
- Excellent mental health care is delivered and research is accelerated.
- Technology is used to access mental health care and information.

It should be further noted that these goals are fully embraced by the Mental Health Division, the leadership of Washington State, the Mental Health Planning and Advisory Council, and the

consumers, families and advocates involved in Washington's public mental health system. Accordingly, the New Freedom goals have been integrated with the goals of the Mental Health Planning and Advisory Council and addressed within the Mental Health Division's Strategic Plan which serves as the platform for Washington's aspiration to achieve transformation.

With these aims in mind, the Mental Health Division strives to combine the best practice standards of the private managed care industry with the core values of the publicly funded mental health system to create a service delivery model that promotes high quality and cost effective services which are consumer driven and focused on recovery and resiliency. We are continually searching for improvements to our system; making certain that access to services consistently meets individual needs, that provision of community linkages are continually strengthened, and that the integration of other publicly funded services and natural supports are unfailingly pursued with the intended outcome being a delivery of care system that is fiscally sound as well as highly responsive.

This past year has been a "banner year" for Washington State in terms of the energy, discussion, and changes that have transpired related to our public mental health system. Although the outcomes of these forces will be more thoroughly discussed in Section C of this plan, to summarize, we have had the unprecedented convergence of several factors:

- The creation of a legislatively mandated Mental Health Task Force charged with assessment of the mental health system and tasked to determine recommendations for improvements;
- A discontinuation of the use of Medicaid managed care savings relied upon to support individuals and services not otherwise eligible for Medicaid. Coupled with the Institution for Mental Diseases (IMD) Exclusion, this posed a significant threat to the foundation of the public mental health system; and
- Passage of legislation that has paved the way for dramatic and far-reaching revisions in the public mental health system including mental health insurance parity, approval of nearly $80 million dollars in state funding to mitigate losses related to the change in the use of Medicaid savings and the IMD exclusion, and a mandatory procurement process for the delivery of managed care services.

The interest and enthusiasm concerning the public mental health service delivery system provides an opportunity for profound change. Lingering uncertainty with regard to implementation of legislation also has limited the ability for forward movement in some areas. For example, MHD is planning to increase accountability and oversight of the mental health block grant contracts through the implementation of pay points. Because the new legislation requires a competitively procured service delivery system, the number and identity of managed care entities will not be fully determined until the spring of 2006. It may be expected that this plan will necessarily be modified if there are changes to the service delivery providers and their proposed use of MHBG funds.

Newly elected Governor Christine O. Gregoire has been clear that the word ***transformation*** is far more than a "buzz-word" in Washington State. Under her guidance, Washington is

demonstrating a firm commitment to all residents, both in policy and in practice, by dedicating the necessary resources, expertise, and visionary leadership toward a future where mental health transformation becomes reality.

The Governor and the Secretary of the Department of Social and Health services (DSHS) recently spearheaded the initiative to further transformation through the application for a Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Transformation System Improvement Grant (referred to as the Transformation Grant). Stakeholders, system partners and community members were invited to inform policy makers in a statewide forum and through internet participation. The forum allowed participants to provide input, to ask questions and to participate in outlining an initial plan for the grant application. An extensive survey was also disseminated and posted on the internet which provided an opportunity for detailed contributions to the planning effort. Finally, the Governor has completed appointment of a Transformation Workgroup comprised of consumers, cross system leaders, family members, community members, mental health providers and other interested parties.

In addition to the application for the Transformation Grant, Governor Gregoire appointed Robin Arnold-Williams to serve as the new Secretary of the Department of Social and Health Services (DSHS), which includes the Mental Health Division along with other social service divisions. Secretary Arnold-Williams recently served under the then Governor of Utah and now Secretary of Health and Human Services, Mike Leavitt. She has initiated structural changes to DSHS by combining the Division of Alcohol and Substance Abuse, the Mental Health Division, and the Medical Assistance Administration under the leadership of tenured Assistant Secretary, Doug Porter. This integration is intended to improve resource management, collaboration, and outcomes for the residents of our state and is viewed as a positive step toward closer alignment of future MHBG goals. By applying for SAMSHA's Transformation Grant, Washington has demonstrated its desire to gain additional resources to help facilitate the goals of the New Freedom Commission as outlined above.

However, it is our leadership, on every level, that has dedicated itself to the necessary culture changes, both in the community and organizationally, that are requisite for such an evolution to occur. Most importantly, the Governor and the Secretary have assured that transformation will move forward, with or without the remuneration of the Transformation Grant. With the political momentum strengthening the growth of the recovery movement, the time is ripe for transformation to come to fruition in Washington State.

It is the sincere desire of everyone involved, from family member to administrator, from consumer to legislator, from case manager to physician that this Mental Health Block Grant plan serves in partnership with the transformation grant as the foundation and structure for meaningful growth and change to our public mental health system.

Part B: Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance

I. Federal Funding Agreements, Certifications, and Assurances

(1)Funding Agreements

The completed "Community Mental Health Services Block Grant Funding Agreements" is shown in Attachment A.

(2) Certifications

The following certifications are shown in Attachment B:

- Debarment and Suspension
- Drug-Free Workplace Requirements
- Lobbying and Disclosure
- Program Fraud Civil Remedies Act (PFCRA)
- Environmental Tobacco Smoke

(3) Assurances

The completed assurances are shown in Attachment C.

(4) Data Universal Numbering System (DUNS) Number

The DUNS number for the Mental Health Division, Department of Social and Health Services is 12-734-7115.

(5) Public Comments on the State Plan

Washington State's Community Mental Health Services Block Grant (MHBG) plan for 2006 was submitted for public comment consistent with the requirements of Public Law 102-321. The MHD State Planner obtained input from the Mental Health Division Management Team, Regional Support Networks and the Mental Health Planning and Advisory Council in developing the 2006 MHBG Plan.

The Mental Health Division formally distributed the Mental Health Block Grant plan for public review during the month of July 2005. Many of the public comments from last year's application have been either addressed through the legislature, added to this plan, or are expected to be incorporated in next year's plan. The following comments were received:

- Over reliance on the medical model further increases the stigmatization of mental illness.
- The term "consumer" should be changed at the federal level. Everyone should use "client" instead or find another, better word.
- There should be mechanisms in place to ensure that there is quality service if a Regional Support Network (RSN) fails the Request for Qualifications (RFQ) and no one else bids for that RSN's catchment area.

- The over-arching goal for the mental health system needs to shift from co-dependency to recovery and autonomy.
- Chiropractic care should be provided in the state hospitals.
- There should be better coordination between MHD and the counties, a number of which have 10-year plans in place to eliminate homelessness.
- MHD needs to do more to address the serious lack of transitional support for foster care children with SED who have moved out of foster care. Equally so, there are little or no transitional supports available for individuals moving from services for children to services for adults.
- MHD needs to improve and increase its use of early intervention strategies.
- MHD needs to demand greater accountability from the RSNs and take a stronger leadership role in ensuring all RSNs get on board with recovery and transformation.
- Liquidated damages hurt the ability of RSNs to deliver community based services and should be stopped.
- Transportation for consumers needs to be given much more attention in terms of funding and availability.
- People want to work. More should be done to increase access to supported employment and to jobs that pay a descent wage.
- MHD should take steps to help individuals who have been cut off from services because they did not have Medicaid. These are the people in our state who are suffering the most, while inappropriately adding to our census issues in the jails and hospitals. The state and RSNs should serve these folks like they used to, and actually *help* them get on Medicaid so they can get treatment, not just occasional crisis care.
- Evidence Based Practices (EBPs) must be the priority. MHD needs to ensure RSNs not only provide EBPs, but that fidelity is met, otherwise you don't have a real EBP.

II. Children's Mental Health Services Report

State Expenditures for Children's Services **FY 1994**	$17,688,942
State Expenditures for Children's Services FY 1997	$39,676,265
State Expenditures for Children's Services FY 1998	$37,069,193
State Expenditures for Children's Services FY 1999	$35,759,268
State Expenditures for Children's Services FY 2000	$37,576,093
State Expenditures for Children's Services FY 2001	$44,265,898
State Expenditures for Children's Services FY 2002	$48,905,080
State Expenditures for Children's Services FY 2003	$55,971,055
State Expenditures for Children's Services FY 2004	$45,688,655
State Expenditures for Children's Services FY 2005 (estimate)	$47,917,076
State Expenditures for Children's Services FY 2006 (estimate)	$56,662,082
State Expenditures for Children's Services FY 2007 (estimate)	$59.398,067

The state and federal funding for Children's Long Term Inpatient Programs (CLIP) were as follows:

Fiscal Year	Services	Administrations
FY2002	$6,040,827	$355,271
FY2003	$6,067,520	$334,267
FY2004	$5,736,897	$386,968
FY2005 (estimate)	$5,754,340	$398,867
FY2006 (estimate)	$6,793,380	$375,600
FY2007 (estimate)	$6,793,380	$375,600

Beginning in SFY 2003, MHD implemented a new payment methodology which combined the inpatient and outpatient capitation payment into one payment. Thus, from SFY 2003 forward, the inpatient expenses which are excluded from this report reflect the actual claim payments.

III. Maintenance of Effort (MOE) Report

Total State Expenditures for Community Mental Health Services

State Expenditures for FY 1996	$138,450,391
State Expenditures for FY 1997	$142,120,995
State Expenditures for FY 1998	$144,140,536
State Expenditures for FY 1999	$146,062,262
State Expenditures for FY 2000	$141,273,152
State Expenditures for FY 2001	$153,423,628
State Expenditures for FY 2002	$156,227,188
State Expenditures for FY 2003	$160,865,058
State Expenditures for FY 2004	$162,114,757
State Expenditures for FY 2005 (estimate)	$177,398,418
State Expenditures for FY 2006 (estimate)	$228,979,741
State Expenditures for FY 2007 (estimate)	$225,895,741

IV. Fiscal Planning Assumptions

The State of Washington was awarded $8,400,033 for the Community Mental Health Services Block Grant for federal fiscal year 2005. The 2006 plan is based on the amount for FFY 2005 and will be amended when the final allocations for FFY 2006 and subsequent years are known, should the final allocation change from the FFY 2005 level.

V. State Mental Health Planning and Advisory Council

(1) Membership Requirements

The Washington State Mental Health Planning and Advisory Council (also referred to as "the Planning Council") and its subcommittees operate under Public Law 102-321 and meet all of the MHPAC requirements set forth therein and by this grant.

(2) State Mental Health Planning and Advisory Council Membership List

Name of Member	Type of Membership	Agency or Organization Representation	Address, Phone, and Fax
1. Thressa Alston	Advocate	Ethic Minority Sub-committee, Program and Planning	20454 104th Avenue SE Kent, Washington 98031 253-859-5309 206-878-3710 ext.3580 talston@highline.edu
2. Graydon Andrus	Provider	Homeless populations representative	Downtown Emergency Service Ctr. 515 Third Avenue Seattle, WA 98144 (206)515-1524 (206) 624-4196 FAX gandrus@desc.org
3. Jeanette Kay Barnes	Consumer Family Advocate Custody of child w/SED	Co-chair Children's Sub-committee	PO Box 723 Enumclaw, WA 98022 206)205-9541 (W) 360-802-6454 (H) Jeanette.barnes@metrokc.gov
4. Rebecca Bates	Consumer Family Advocate Parent of children with SED	Children's Sub-committee	525 W. 2nd Avenue Spokane, WA 99201 (509)892-9241 bbates@voaspokane.org
5. Roger Bauer	Provider		PO Box 3208 Omak, WA 98841 (509) 826-8420 rbauer@okbhc.org
6. Chuck Benjamin, Vice-Chair	Provider	Regional Support Network, Chair of Legislative Sub-committee,	North Sound RSN 117 N 1st Street STE #8 Mt. Vernon, WA 98273-2858 (360)416-7013 ext. 39 charles_benjamin@nsrsn.org
7. Lou Colwell	State Employee	Office of Superintendent of Public Instruction, Special Education representative, Program and Planning	Special Education Section OSPI PO Box 47200 Olympia, WA 98504 (360) 725-6075 (360) 586-0247 FAX Lcolwell@ospi.wednet.edu

Name of Member	Type of Membership	Agency or Organization Representation	Address, Phone, and Fax
8. B.J. Cooper	Consumer	Legislative Sub-committee	mhbills05@yahoo.com
9. Rick Crozier	Provider	Chair of Older Adult Sub-committee, Program and Planning	Older Adult Program Manager Good Samaritan BH 325 E. Pioneer Ave. Puyallup, WA 98372 253-697-8547 rickcrozier@goodsamhealth.org
10. Kelly Egan	State Employee	Department of Corrections representative	MH Program Director PO Box 41126 Olympia, WA 98504-1126 (360) 586-9524 (360) 586-4577 FAX kjegan@DOC1.wa.gov
11. Holly Elsten	Parent of child with SED, Advocate		Wilkeson, WA 98396 hollyelsten@yahoo.com
12. Danny Eng	State Employee	Division of Vocational Rehabilitation representative	14360 SE Eastgate Way N 40-3 Bellevue, WA 98007 (425) 649-4235 Engd@dshs.wa.gov
13. Diane Eschenbacher	Consumer Advocate		Spokane, WA 99204 dianeresch@netzero.com
14. John Fisher	Consumer Advocate		8124 69th Ave SW Lakewood, WA 98499 (253) 584-9330 (H) (253) 584-9330 FAX call first hjFisher55@aol.com
15. Joann Freimund, Chair	Advocate	Chair of MHPAC, Program and Planning Sub-committee	3739 Goldcrest Hts. NW Olympia, WA 98502 (360) 866-1575 jgfreimund@aol.com
16. Michael Haan	Consumer	Legislative Sub-committee	11457 70th Place S. Seattle, WA 98178 (206) 383-4550 mhaan@perkinscoie.com
17. Diana Jaden-Catori	Consumer	Legislative Sub-committee	630 N. Arthur St. #A Kennewick, WA 99336 (509)735-8681 Dianaj@gcbh.org

Name of Member	Type of Membership	Agency or Organization Representation	Address, Phone, and Fax
18. Douglas Johnson	Provider	Chair Sexual Minorities Sub-Committee, Program and Planning Sub-committee	Greater Columbia BH 101 N. Edison Kennewick, WA 99336 (509) 735-8681 douglasj@gcbh.org
19. Brett Lawton	State Employee	Medical Assistance Administration	Medical Assistance Administration PO Box 45530 Olympia,WA 98504-5530 (360) 725-1593 lawtobl@dshs.wa.gov
20. Candise Manke	Family member of person with SMI Advocate		PO Box 4122 Wenatchee, WA 98807 509-884-9601 (H) ablastfromthepast@msn.com
21. Cathii Nash	Consumer Family Advocate	Legislative Sub-committee Program and Planning Sub-committee	3908 E. 17th Spokane, WA 99223 (509) 536-4136 cathiin@netzero.com
22. Steve Norsen	State Employee	Mental Health Division	Mental Health Division PO Box 45320 Olympia, WA 98504-5320 360-902-0848 NORSENS@dshs.wa.gov
23. Eleanor Owen	Family Advocate	Program and Planning Sub-committee	906 East Shelby Seattle, WA 98102 (206) 322-0408 (206) 227-4661 eleanor_owen@mindspring.com
24. Andy Pascua	Advocate	Chair of Ethnic Minority Sub-committee	702 South 32nd Avenue Yakima, WA 98902 (509) 248-6929 carriehp@aol.com
25. Barbara Putnam	State Employee	Children's Administration Children's Sub-committee, Program and Planning	14th and Jefferson, MS: 45710 Olympia, WA 98504-5710 (360) 902-7939 PUBA300@dshs.wa.gov
26. Dorothy Trueblood	Parent of child with SED		6031 S. Warner Tacoma, WA 98409 (253) 472-1442 dorothyt@ccsww.org

Name of Member	Type of Membership	Agency or Organization Representation	Address, Phone, and Fax
27. Barbara St. Louis	Parent of child with SED	Children's Sub-committee	1204 Washington Ave. Hoquiam, WA 98550 (360) 537-2109 bastlouis@doc1.wa.gov
28. VACANT POSITION	Consumer		To be filled by Oct 2005
29. VACANT POSITION	Consumer family member		To be filled by Oct 2005
30. VACANT POSITION	State Employee	Housing Representative	To be filled by Nov 2005
Bronwyn Vincent	State Employee MHD staff to the committee (non-member)	Mental Health Division	PO Box 45320 Olympia, WA 98504-5320 (360) 902-0822 (360) 902-0809 FAX vincebv@dshs.wa.gov

Planning Council Composition by Type of Member:

Type of Membership	Number	% of Total
Consumers	8	
Family members of Children with SED	3	
Family members of Adults with SMI	2	
Others: not state employees or providers	3	
Vacancies	2	
TOTAL (consumer, family, and others minus vacancies)	16	59%
State Employees	6	
Providers	5	
Vacancies	1	
TOTAL (State Employees and Providers minus vacancies)	11	41%

The Planning Council has successfully recruited new members from its Standing Subcommittees. For example, if the Planning Council needs a new member who is a parent of a minor child with a serious emotional disturbance, a request is made to the Children's Treatment and Services Subcommittee to make a recommendation. This has resulted in new members having a greater knowledge of the Planning Council Goals and how it operates.

(3) Planning Council Charge, Role and Activities

The Mental Health Planning and Advisory Council established the following Vision, Mission and Goals to guide the work of the council:

VISION:

Plan, Advocate, Evaluate

MISSION:

To advocate for a system that supports persons impacted by mental disorders on their journeys to achieve the highest quality of life possible by promoting evidence-based, cost-effective, individualized mental health services.

GOALS:

The Goals of the Mental Health Planning and Advisory Council shall be to transform the mental health system consistent with the goals of the President's New Freedom Commission on Mental Health, as follows:

Primary Goals:

A. Washington State residents acknowledge that mental health is essential to overall health.

B. Mental health care is consumer and family driven.

C. Disparities in mental health services are eliminated.

D. Early mental health screening, assessment and referral to services are common practice.

E. Excellent mental health care is delivered and research is accelerated.

F. Technology is used to access mental healthcare and information

Other Goals:

A. Oversee the Federal Block Grant, including recommending the plan, amendments and reports submitted by the Mental Health Division to the Center for Medicaid and Medicare Services.

B. Develop and take advocacy positions concerning legislation, funding and regulations affecting mental health services through the use of mental health statistics for decision making and planning.

C. Support and advocate for quality, cost effective and individualized consumer/family based services through evidence based best practice models of care. Support research and use of promising practices through continuous quality improvement.

D. Promote optimal functioning for consumers across the life domains by removing barriers to services. The Council's focus will be education for children; supported employment for adults; and/or meaningful daily activities for older adults.

E. Support education about mental illness and other mental disorders in an effort to reduce stigma.

As a result of Planning Council trainings and attendance to national conferences, the Planning Council has reorganized its structure to establish the following Standing Subcommittees to carry-out its mission and to meet its goals:

- Legislative/Administrative Subcommittee,
- Program/Planning Subcommittee,
- Children's Treatment and Services Subcommittee,
- Sexual Minority Treatment and Services Subcommittee,
- Older Adult Treatment and Services Subcommittee, and
- Ethnic/Cultural Minorities Treatment and Services Subcommittee.

For communication purposes, the Planning Council is at the apex of a triangle. The Legislative and Program/ Planning Subcommittees are the next step down. The four remaining Subcommittees form the base of the triangle.

A representative of each Standing Subcommittee is designated in the Bylaws as a member of the Planning Council. Each Standing Subcommittee is charged by the Planning Council to focus their attention on the implementation of the Goals and Purpose of the Planning Council. Therefore, on the Planning Council Meeting Agenda, Subcommittee reports reflect the Planning Council Goal being discussed or implemented.

Through the trainings the MHPAC has received from the National Association of Mental Health Planning and Advisory Council and the National Technical Assistance Center for State Mental Health Planning, the Council has been infused with a thorough understanding of the President's New Freedom Commission on Mental Health report, Achieving the Promise: Transforming Mental Health Care in America. As a direct result, the MHPAC changed its Bylaw goals to include the New Freedom Commission goals as well as other MHPAC goals outlined above.

Further related to this increased expertise has been the MHPAC's focus on increasing consumer and family involvement at the onset of all MHD policy, planning, and implementation endeavors. This has lead to a change of culture at the Division which supports the common goal of improving the quality of life for adults with severe mental illness and children with serious emotional disturbances.

Before listing the accomplishments of the MHPAC over the last year, it should be noted that the work of the sub-committees has served not only to forward the mission and goals of the MHPAC, but to bring greater awareness and understanding to their representative populations through advocacy as well as sponsorship of conferences, trainings, and community education

projects.

The following is a list of the MHPAC accomplishments for 2004-2005:

- Ongoing monitoring of the MHBG including considerably increased input into the MHBG applications, Implementation Reports, the RSN contracts and Modification Requests since 2005. Specific to the latter, the Council voted *not* to recommend the Division's use of FFY 2005 Modification funds for the Mentally Ill Offenders (MIO) program. The Council's reasoning was that doing so would continue the legislatively mandated use of MHBG monies without consultation of the Council which is federally mandated to oversee MHBG funds.

- Formation of a Council Ad Hoc Sub-committee to review MHD's Strategic Plan. This resulted in a complete revision of the plan to include the six goals of the President's New Freedom Commission, other state related strategies, and quantifiable measures with direct accountability.

- Involvement in the Governor's team for Washington's Transformation Grant application and subsequent appointment to the Governor's Transformation Work Group.

- Formation of a Council Ad Hoc Sub-committee to work with MHD in the creation of the current RSN/MHD contracts for Pre-paid Inpatient Health Plan services to Medicaid enrollees and the RSN/MHD contract for services funded with "state only" dollars. Again, the purpose was to incorporate the President's New Freedom Commission goals and to ensure that consumer, family, and advocate voice was clearly heard from the beginning in the very important process of culture change.

- On-going involvement with the Mental Health Task Force (MHTF), including giving testimony on the Council's opinion about how to prioritize the use of state only funds afforded to the mental health system. Ultimately, the Legislature provided over $80 million dollars to ease the losses related to revisions in the use of Medicaid savings for non-Medicaid consumers and services.

- Active monitoring and support by the Legislative Sub-committee on the Mental Health Parity bill which was passed this session, as well as other important pieces of legislation aimed at reforming the public mental health system. The President's New Freedom Commission's language and goals were profusely included.

- Participation in the development of the Peer Support Training Curriculum and ongoing advocacy for Peer Support.

- Invitation to give input, as well as encourage input from other stakeholders, to the Seattle Regional Office Centers for Medicaid and Medicare Services Review.

- Reception of the MHBG Review Team at the April 2005 MHPAC meeting. The exit interview and final report articulate multiple compliments about MHPAC involvement in the state mental health system.

- Support of the use of Evidence Based Practices (EBPs). All MHPAC reviews of MHBG proposals, the Strategic Plan, RSN contracts, etc., are made with EPBs in mind.

- Co-sponsorship of an Americans with Disabilities Act (ADA) celebration with several other federally mandated state councils.

- Collaboration with MHD through regular meetings on policy and implementation ideas.

- Inclusion of the MHPAC on the MHD Organizational Chart.

- Establishment of annual awards for exceptional service to children and older adults. This year's annual Stakeholder meeting will provide three awards for these services within the ethnic/cultural community.

- Involvement in the interview panel to hire a new MHD Director.

- Participation in relationship building with all areas of state services including a planned visit by the new DHSH Secretary, Robin Arnold-Williams.

- Fulfillment of all of the MHPAC's duties and membership requirements mandated by law.

(4) Mental Health Planning and Advisory Endorsement/ Recommendations:

Mental Health Planning & Advisory Council

Vision
Plan, Advocate, Evaluate
Mission
To advocate for a system that supports persons impacted by mental disorders on their journeys to achieve the highest quality of life possible by promoting evidence-based, cost-effective, individualized mental health services.

Joann Freimund, Chair
3739 Goldcrest Hts. NW
Olympia, WA 98502
(360) 866-1575

July 28, 2005

LouEllen M. Rice
Grants Management Officer
Division of Grants Office, Room 7-1079
Division of Grants Management,
SAMHSA
One Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

The purpose of this letter is to document that the Washington State Mental Health Planning and Advisory Council (MHPAC) voted to recommend the Washington State 2006 Community Mental Health Services Block Grant Application on July 20, 2005. Improving the delivery of services for persons with mental illness continues to be a first priority of Washington State and MHPAC. The State and MHPAC are working together to implement the President's New Freedom Commission on Mental Health.

As you can see from the content of this 2006 FBG Application, 2004 and 2005 were banner years for the mental health system in the State. Rather than duplicate the 2006 FBG Application information, I would like to refer you to the MHPAC section in the Application's Part B which list MHPAC's 16 accomplishments during 2004 &2005. The concept of Transformation is clearly embedded in the thinking and implementation at the State Legislature, the Mental Health Division and MHPAC level.

Despite proactive action by MHPAC, the 2005 Legislature continued the mandate of using FBG monies for the Mentally Ill Offender Program in King County without involving MHPAC in the process. As a result, MHPAC wrote a letter to you NOT recommending the FFY 2005 Modification. MHPAC feels very strongly about its federally mandated role "to review the Mental Health Block Grant and to make recommendations". A positive recommendation would erroneously infer that MHPAC is

merely “rubber-stamping” whatever the Legislature mandates.

It was truly exciting to recently receive the SAMHSA news announcement: Federal Action Agenda. The Mental Health Action Agenda represents quantum leaps in system transformation. On behalf of MHPAC, I wish to express our appreciation for the many forward thinking people at the federal level to make what appeared to be an impossible dream and real reality.

Sincerely,

(Signature on file)

Joann Freimund, Chair
Mental Health Planning and Advisory Council

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Part C: The State Plan Context

SECTION I: Description of State Service System

Mental Health Division's Scope and Responsibilities

As the mental health authority for the 6,167,800 residents of Washington State, the Mental Health Division (MHD) operates an integrated system of care for people with mental illness who are enrolled in Medicaid as well as for those individuals who qualify as "low income" who also meet the statutory need requirements.

MHD is a division within the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS). The Secretary of DSHS is appointed by the Governor to this Cabinet-level position, overseeing several other administrations within DSHS including; the Aging and Disability Services Administration, the Children's Administration, the Economic Services Administration, and the Juvenile Rehabilitation Administration. HRSA sister agencies to MHD include the Division for Alcohol and Substance Abuse and the Medical Assistance Administration.

In 1989, the Washington State Legislature enacted the Mental Health Reform Act; a measure which consolidated responsibility and accountability for the provision and oversight of community mental health treatment with the creation of 14 Regional Support Networks (RSNs). The RSNs are under direct contract with MHD to ensure quality outpatient services for individuals with mental illness, including crisis response and management of the involuntary treatment program.

Beginning in October 1993 through 1996, MHD implemented a capitated managed care system for community outpatient mental health services through a federal Medicaid waiver, thereby creating prepaid health plans operated by the Regional Support Networks. In 1996, the waiver was amended to include community inpatient psychiatric care and, by 1999, all Regional Support Networks were responsible for management of inpatient community mental health care in addition to outpatient services.

The current community mental health system operates under Chapters 71.24, 71.05, 38.52, 74.09 and 71.34 of the Revised Code of Washington (RCW) and under a 1915b Medicaid waiver from the federal Centers for Medicare and Medicaid Services (CMS). The waiver allows the state to operate a managed care model. Within the managed care framework, RSNs operate under two contracts with MHD; one contract is a Prepaid Inpatient Health Plans (PIHPs) for Medicaid enrollees and the other as a State funded contract for non-Medicaid services. Under both contracts the RSNs are to ensure the provision of community inpatient and outpatient services. The RSNs accomplish this by contracting directly with community providers who then actually deliver the services.

In addition to oversight of the mental health system, MHD is responsible for resolution of

consumer grievances that require State-level intervention as well as the coordination of emergency preparedness and response to such incidents as natural disasters and acts of terrorism.

In 2004, the State Legislature convened a Joint Legislative and Executive Task Force on Mental Health Services Delivery and Financing, commonly referred to as the Mental Health Task Force (MHTF). The charge of the MHTF was to assess the strengths and areas for improvement within the entire public mental health system. This 8-member committee, along with a 16-member Advisory Committee on Bed Needs, an 8-member Advisory Committee on non-Medicaid Services, and a 13-member Advisory Committee on System Organization and Accountability was created to address the following issues:

- Funding for non-Medicaid consumers;
- Residential and inpatient bed needs;
- Administrative structure of the community mental health system;
- Alternative payment models;
- Performance-based outcome measures; and
- Reducing administrative requirements.

After an exhaustive year of receiving highly detailed research from legislative staff, reviewing comprehensive reports from MHD staff, and hearing hours of testimony about Washington's mental health service system from providers, consumers, family members, law enforcement officials and other stakeholders, the MHTF recommended several improvement strategies to the legislature, contained in Attachment E.

The State Legislature, with acknowledgment of MHTF recommendations, voted to enact legislation that will fundamentally change the process by which the public mental health system is administered. House Bill 1290 provides for the following:

- Extends by one year the duration of the MHTF, which was initially only called into existence for one year;
- Directs the Department of Social and Health Services to establish statewide minimum qualifications by which the fourteen existing RSNs will be evaluated against through a Request For Qualifications (RFQ) process resulting in the award or denial of a contract for mental health services with the Mental Health Division;
- Directs the Department of Social and Health Services to administer a competitive procurement process for mental health services through a Request for Proposal (RFP) in each region where a Regional Support Network failed to meet the requirements of the RFQ;
- Effectively removes the "right of first refusal" to accept the contract for mental health services by the RSNs and removes the requirement that an RSN be a county-based entity;
- Directs the Economic Services Administration to develop and adopt Washington Administration Code outlining procedures by which restoration of Medicaid benefits to consumers who are released from jail or prison may be expedited, thereby intending to impact the risk of re-offense.

- Directs the MHTF to provide oversight of the RFQ and RFP processes as well as oversight of the pending reorganization of state level administration and responsibilities of the public mental health system.

An RSN must demonstrate substantial compliance with the requirements of the Request for Qualifications in order to continue administering mental health services through a contract with the Mental Health Division. The MHD has contracted with a nationally recognized entity to assist in developing the RFQ. The organization is experienced in managed mental health care, mental health service delivery and design and includes staff with expertise concerning the federal regulations and the current industry standards in the behavioral healthcare field. The RSNs must demonstrate their ability to meet the qualifications of the RFQ in order to be awarded the contract for mental health services to be executed on September 1, 2006. The RFQ must be published on October 1, 2005. The RFQ is limited to responses from the current RSNs.

If an existing RSN fails to meet the requirements of the RFQ or does not respond, the region will be open for competitive bid in a subsequent Request for Proposal process. Another RSN, a for-profit managed care entity, a non-profit entity, a consortium of RSNs or any other organization able to demonstrate compliance with the required qualifications will be able to submit an application to provide services in that geographic area.

At the time of submission of this MHBG plan, it is impossible to know which RSNs will meet the rigorous demands of the RFQ. The precise number of RSNs may also change if regions submit responses jointly. Consequently, planning is difficult, not just in terms of the MHBG, but in relation to the general business of administering the public mental health system.

While the MHTF offered suggestions for improvement, it also gave recognition and positive attention based on the many accomplishments of the MHD, the RSNs, the providers, and the overall system. In particular, the MHTF acknowledged MHD efforts to increase the use of Evidence Based Practices in therapeutic foster care. This effort is occurring through the Children's Mental Health Initiative. The initiative seeks to implement Multi-dimensional Treatment Foster Care based on the Oregon Social Learning Theory, a recognized EBP, along with four other evidence based practices for children and youth.

In summary, MHD continues to build upon our regional partnerships to create the best service standards possible from two major models of service:

- Public Mental Health (historically this model has provided population-based care for those who are most at risk and least able to access services) and
- Private Managed Care (the principles and tools of which provide guidance for clarity, accountability, utilization management, and fiscal alternatives to minimize the escalating costs of public mental health care).

With the potential systemic changes before us, MHD's leadership will be pivotal in the on-going efforts to meld these two models. Supporting that leadership will be the oversight of the MHTF and the collaboration with both the MHPAC and the Governor's Transformation Workgroup.

Critical to Washington's success will be the collective resolve of these entities to enable the ultimate goals of recovery and resiliency to become reality. While the process continues to prove challenging, it is equally rewarding as Washington moves toward the transformation of a system whose quest is to create and enhance an environment wherein recovery and resiliency are not only attainable, but sustainable, were access to quality services is consistent throughout the state, and where individuals with mental disabilities have real hope for real recovery.

Regional Support Networks' Scope and Responsibilities

Under the direction of CMS, MHD has separated what was previously a single contract into two separate contracts with the RSNs: the PIHP contract for Medicaid services and the "state only" contract for non-Medicaid services and individuals. The latter assigns the RSNs responsibility for services described in state statute. These services include community support, employment, and residential services for persons meeting statutorily defined categories based on need. Community support services are described in Chapter 71.24 RCW but must cover at least the following six service areas:

- Emergency crisis intervention services;
- Case management services;
- Psychiatric treatment including medication supervision;
- Counseling and psychotherapy services;
- Day treatment services; and
- Consumer employment services.

With regard to residential and housing services, the Regional Support Networks must ensure:

- The active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.
- The provision of services through outreach, engagement and coordination or linkage of services with shelter and housing to families of eligible children and to eligible consumers who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77.
- The availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, including a full range of residential services and residential supports described in the consumer's treatment plan.
- The eligible individuals residing in long-term care and residential facilities are apprised of their rights and receive mental health services consistent with their individual service plans.

RSNs and their sub-contracted licensed community mental health agencies (CMHAs), coordinate with rehabilitation and employment services to assure that consumers who want to work are provided with employment services. Case managers then assist consumers in achieving the self-

determined goals articulated in their individual service plans by providing access to employment opportunities such as:

- A vocational assessment of work history, skills, training, education, and personal career goals;
- Information about how employment will affect income and benefits the consumer is receiving because of their disability;
- Active involvement with consumers served in creating and revising individualized job and career development plans;
- Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests;
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and
- Interaction with the consumer's employer to support stable employment and advise about reasonable accommodations in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Anti-discrimination law.

All of the services outlined above are to be provided “within available resources” meaning all services may not be available in all areas of the state.

In addition to these services, RSNs administer the involuntary treatment program and the crisis response system for the citizens of Washington State residing in their catchment areas. In most communities, crisis and involuntary services are highly integrated. The mental health system and the RSNs operate the only behavioral health crisis system in the state, resulting in responsibility by default for conditions not normally considered as mental illness. These crisis services are available to anyone in the state, regardless of income.

Crisis services include a 24-hour crisis line and in-person evaluations for individuals requesting crisis intervention or for those individuals presenting with mental health crises. These difficult situations are resolved in the least restrictive manner and include family members and significant others as appropriate to the situation and as requested by the individual in need. For many consumers receiving services through the CMHAs, there is on file an Individual Crisis Plan (ICP). The ICP contains the preferred intervention strategies put forth by the consumer and their families. Further, many consumers also utilize Advance Directives describing their desired outcomes should more restrictive measures be required to provide for their own safety or the safety of others. In addition, RSNs ensure access to other necessary services such as medical services and medication, interpretive services, staff with specialty expertise, and access to the involuntary treatment program.

Involuntary treatment services, as part of crisis services, are available in all of the communities of the state 24-hours per day. These services include a face-to-face evaluation of the need for involuntary psychiatric hospitalization. General criteria for such involuntary services include being determined by a County Designated Mental Health Professional (CDMHP) to be either gravely disabled or at risk of harm to self, others, or property as a result of a mental disorder. Alone, neither risk of harm nor a mental disorder, are sufficient to justify the loss of an

individual's right to make decisions about their own care. Further, the danger must be the result of the mental disorder. While local decisions related to 72-hour involuntary detentions are made by community based CDMHPs, state courts determine subsequent fourteen day or ninety day commitment decisions. Individuals needing involuntary care may receive it in community hospitals, in freestanding evaluation and treatment facilities, in one of the three state-operated psychiatric hospitals or in one of the three Children's Long Term Inpatient Residential Treatment Facilities for Psychiatrically Impaired Youth.

As a separate contract, the RSNs operate as a pre-paid inpatient health plan (PIHP) by administering a full continuum of community mental health services as defined in the Medicaid State Plan and Amendments (SPA) and as described in the 1915(b) waiver for managed care. A few of these services include:

- Comprehensive face-to-face treatment activities designed to help the consumer attain goals as prescribed in the consumer's individual service plan. These services shall be congruent with the age and cultural framework of the individual and may be conducted with the consumer, his or her family, or others who play a necessary role in assisting the consumer to maintain stability in living, employment, or educational environments. These services may include, but are not limited to: developing the consumer's independent self care skills, monitoring and supervision of the consumer's functioning, health services, counseling, and psychotherapy.
- Appropriate prescription and administration of medications including responsible reviews of medications and their side effects and consumer/family education related to these. This service shall be rendered face-to-face by a person licensed to perform such services.
- Effective hospital diversion services which are a less restrictive alternative to inpatient hospitalization, or are a transitional program after discharge from inpatient services. These services are designed for persons with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. These services include a mix of individual, group services and crisis services.

All of these important PIHP services are funded according to the number of Medicaid eligible persons living in each RSN's catchment area. The funding mechanism does not necessarily mirror demand for mental health services, since community mental health service demand tends to be stable as Medicaid caseloads vary.

As prepaid inpatient health plans, RSNs authorize and pay for voluntary community inpatient psychiatric care for residents in their catchment areas. As Medicare and private insurance continue to cut costs by trimming services and rates, community hospitals are examining their operations in order to eliminate or curtail services that are not cost effective. The result is that community hospitals are downsizing or threatening to close psychiatric wards. This situation is compounded by the fact that mental health costs grow at a rate higher than the state expenditure limit, similar to other health care costs. In an effort to help provide some relief to the hospitals, the legislature recently approved a hospital rate increase for those hospitals certified to accept individuals who are involuntarily detained.

As with all health care, community based outpatient services are preferable when it comes to the diagnosis and treatment of health conditions. However, when acute situations arise or when outpatient services are unable to alleviate the presenting condition, inpatient hospital care often becomes a necessary and critical resource.

State Hospital Services

The Mental Health Division operates two adult psychiatric hospitals and one psychiatric hospital for children. Overall, these hospitals provide care for approximately 1,300 adults and 47 children each day. The state continues to struggle with the higher expectations for patient care from the courts, the legislature, CMS, and the accrediting organizations (e.g.: The Joint Commission of Accredited Healthcare Organization). The Mental Health Division also holds contracts for the operation of three children's long-term inpatient programs (CLIP). These facilities provide capacity for 44 children statewide.

Within the adult hospitals, there are two systems of care: civil and forensic. Patients can enter the civil wards of the hospital through a voluntary admission (though this is rare as voluntary admissions are addressed through community hospitals) or through an involuntary civil commitment. There are processes whereby a patient may be civilly committed upon being discharged from the criminal justice system, or patients may be civilly committed without entering the criminal justice system.

Since the state hospitals are funded at a level tied to a legislatively defined "funded capacity" or census, the adult hospitals are at risk of over-expenditure if patients are admitted beyond the funded capacity, even though patients admitted under criminal statutes cannot be turned away. As state hospital civil capacity is an integral part of the community's resource for treating persons with mental illness, the RSNs are responsible for maintaining their use of state hospital capacity within contractual limits. To strengthen the expectation that individuals will be served in the community whenever possible and appropriate, the state has implemented Liquidated Damages as a disincentive. When the aggregate count of the daily census exceeds the legislatively funded limit, those RSN's who have surpassed their allocated bed limit are charged the cost of care per individual per day. This practice, while unpopular with many, has served to meet the state hospital budgetary requirements for the staff overages that come with increased numbers of patients. (Of note, the MHD has sought and received legislative funds this session to develop incentives for the RSNs as another, more positive approach to mold desired outcomes).

To address these issues, the MHD is conducting studies to examine need within the community system and is continuing to identify enhancements at the state hospitals that will increase revenue collection. The focus of one study is on the need for inpatient capacity for persons with mental illness and the appropriate capacity of state hospitals. An actuarial study has also been conducted to identify the overall funding needs of community managed care programs.

While the Division continues to ensure that state hospital billings are compliant with federal rules for reimbursement, it is also seeking to improve the processes by which that is

accomplished. Accordingly, the State Hospitals Integrated Patient Information System project (SHIPS) was created. Expected outcomes of SHIPS include:

- Increase revenue enhancement potential;
- Decrease use of manual processes through increased automation;
- Decrease fragmentation through increased interface;
- Obtain a computer infrastructure that is "user- friendly", cost effective, meets the diverse needs and applications of its users and is less cumbersome to manage.

In addition to the hospitals improving their ability to report fiscal and clinical data, MHD hopes to improve financial reporting requirements for the RSNs in an effort to ensure that funds spent and allocated on certain client groups are appropriately reported to the legislature and to other stakeholders.

The forensic (legal) wards of the state hospitals are entered through the criminal justice system. Services provided are generally evaluations, restoration of competency to stand trial, and care of those found not guilty by reason of insanity. State hospital forensic census is controlled by criminal law changes and court action. The most significant impacts on forensic services have come about as a result of recent legislation affecting offenders with mental illness. These laws have generally increased the number of persons served by the forensic units at the hospitals and have resulted in some evaluation services being performed at community jails.

Unequivocally, there has been a steady rise in the numbers of individuals requiring these evaluations, such that the state hospitals have been at risk of both receiving court fines and being found in contempt of court for not providing timely evaluations and restorations. Though not yet in Washington statute, our legal system is taking heed of a recent decision in a neighboring state that mandated a seven day limit between the date a judge orders competency restoration and the date of admission. With this in mind, MHD has taken measures to obtain increased funding to hire more evaluators and increase forensic bed capacity; moves which have provided some respite. Though hard data have not yet been formally collected, many speculate these efforts to be a temporary remedy as they contend the issue is more systemic; believing there is a corollary relationship between the cuts that community mental health centers have been forced to make (resulting in the cessation of services to individuals who do not have Medicaid) and the considerable increase in the call for forensic evaluations.

Although the state hospital census is always an issue, progress has been made in the reduction of long-term hospital utilization. During the spring of 2003, DSHS completed the final round of transitions of long-term state hospital patients into community settings through the Expanding Community Services (ECS) Initiative. The ECS program transferred state hospital funding to develop enhanced community resources which serve state hospital patients with barriers to discharge. Some of these resources are also being used to provide services to individuals at risk of re-hospitalization.

The program is primarily designed for long term patients who had been at the state hospitals between 2-32 years. Now that these individuals have returned to their home communities, many

have reconnected with family and some have started working. There has been very low recidivism for the individuals served through the ECS program. The ECS program is currently serving 120 older adults with mental illness and/or severe dementia and 60 adults with severe mental illness. A total of 178 state hospital beds were closed as a result of the program.

Community Hospital Services

Washington hospitals are facing financial hardship and consequently curtailing services in many communities. In February 2000, the state Department of Health reported that the community hospitals had the lowest net income for any annual period since the state began to collect hospital financial information more than 40 years ago. While hospital costs continue to rise, reimbursements have not kept pace. New life saving technologies – including pharmaceuticals – improve patient care but cost more, and the additional costs are typically not reimbursed by all insurers. Accordingly, hospitals are experiencing a worsening shortage of nurses and other medical personnel exacerbated by rapidly increasing recruitment and retention costs.

The 1997 Federal Balanced Budget Act cut more than $1 billion dollars in payments to Washington State's community hospitals from 1998-2002. The 2000 state legislative session provided clear evidence that the combined effects of the state's I-601 spending limit, the significant loss of revenue as a result of the state's I-695, and increased demands for education and transportation dollars will continue to place the state's health care budget in serious jeopardy of erosion.

Hospital operating margins have plummeted to dangerous and historically low levels. This shortfall often forces hospitals to decrease services as well as inhibits investment in new medical technologies or renovation of aging buildings and facilities. Hospitals experiencing years of low or negative operating margins face an uncertain future including, in some cases, the threat of closure. This is despite the fact that Washington's community hospitals are among the most efficient and low-cost in the nation.

Recent years have been marked by significant changes in the mental health inpatient service delivery system. There has been planning and implementation for greater use of community hospitals for inpatient psychiatric services in lieu of utilization of the state hospitals. With no end in sight to the rising costs of care, hospitals that once took psychiatric patients through the Medicaid system no longer will, or in the worst case scenario, these community hospitals have closed their doors completely.

Exacerbating these financial stressors has been the change in the way in which CMS has viewed the use of Medicaid savings. In the past, whether or not a facility was an Institution for Mental Disease (IMD) was of little or no consequence in relation to paying for inpatient care in that RSN's could use the Medicaid savings remaining from their capitated rates to pay for non-Medicaid services. RSN's must rely on their scarce "state-only" dollars to pay for these important services or risk the facilities closing. If the latter were to occur, the only safe place for someone needing inpatient care would be the state hospitals, which as mentioned earlier, have a

mandated census limit and when an RSN exceeds that limit, Liquidated Damages go into effect, further impacting the financial penalty. Consequently, the monetary resources that would have been available to provide for other critical services, such as residential and vocational supports, are diminished or become non-existent.

The Washington State Legislature rose to the call for help by providing nearly $80 million dollars in "state-only" funding to support continuation of non-Medicaid services. While they have infused the system with new state dollars during this budget cycle, changes must occur in related to our state's use of IMDs. There are no guarantees this level of funding will continue in future budgets.

Children's Services

The planning system and infrastructure for the delivery of children's mental health services is much the same as the adults. The 14 RSN's must provide a complete array of services to children through sub-contracts with the local community mental health agencies for provision of direct care services to individuals in this vulnerable population who are found to have Serious Emotional Disturbances (SED) and for whom the medical necessity criteria are met.

Between nine percent and thirteen percent of children (age 9-17) have serious emotional disturbances that effect their functioning in family, school or community activities. There are an additional number of children identified by the school system as having a serious behavioral disability. These children are served not only by the mental health and the school systems, but often times are recipients of services by the Children's Administration (child welfare system), Juvenile Rehabilitation Administration, Medical Assistance Administration, Division of Alcohol and Substance Abuse, and/or the Department of Health.

Youth may have multiple issues including: mental illness, substance abuse, repeated patterns of property destruction, assaultive behavior, sexually offending behavior, fire-setting behavior, and/or significant cognitive impairments. Children and adolescents with the most severe disorders usually have needs that require services from at least two child serving systems, along with medical care and other support. These children may have histories of being bounced from one service system to another including: child welfare, mental health, juvenile justice, substance abuse, developmental disability and special education.

All too often, children are not identified as having mental health problems and those who do not receive timely and effective services may end up in jail. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low prioritization for resources (Surgeon General's Report on Children's Mental Health, 2000).

It is important that care coordination exists for these children and their families. The family should not have the additional burden of coordinating with multiple systems that assist them. To the contrary, the systems should work together to serve the child. Additionally, it should also not be necessary for parents to relinquish custody and care of their children to get services they need

as has been the case in the past wherein a parent who could not meet the state eligibility criteria to obtain care for their child made the difficult choice to relinquish custody, thereby making the child a ward of the state in order for the child to become eligible.

A growing informal network of parents and advocates is beginning to be recognized by allied systems of the mental health structure resulting in an increasing number of conversations with other programs about the utilization of parents, neighbors and friends in the support of children with SED. The mental health system has received requests for technical assistance on the best way to incorporate family and friends into the planning process to help children with serious emotional or behavioral needs. Although this network has become more accepted by providers as their community involvement expands, they are, unfortunately, not yet seen universally as a resource. This group, however, has a strong belief in their role as a system partner and plans to continue to be involved as coordination and recognition continue to grow.

One way this coordination is happening is through the Statewide Action for Family Empowerment of Washington (SAFE-WA) formerly known as the Parent Council. This valuable organization is supported by the Mental Health Division, was the recipient of a SAMHSA grant in 2001, and has recently received its 501(c) 3 status. SAFE-WA is comprised of eleven family-driven organizations and a youth organization. SAFE-WA meets quarterly to bring a united voice to the Mental Health Division's management on salient children's issues.

Over the course of many biennia, training and technical assistance on the use of innovative methods of cross-system partnerships to deliver coordinated care have been provided. In addition, numerous local and national reports on coordinated care and best practices have been written. What has not accompanied this, however, is the funding and high level commitment in allied systems of care to support the growth and cohesion of children's services.

Imperative to the development of an effective system of care for children with SED and their families is collaboration. In an effort to reduce gaps in care, improve consistency of supports, and reduce duplication of services, MHD is working closely with other DSHS agencies such as the Juvenile Rehabilitation Administration and Children's Administration in creating the Children's Mental Health Initiative. Through this joint venture, all parties hope to increase resource management and find better ways to incorporate evidenced based practices with the ultimate goal being improved care with demonstrated outcomes for children with complex, multi-service needs.

SECTION II – Identification/Analysis of System's Strengths/ Needs/Priorities

Criterion 1: Comprehensive Community-Based Mental Health Service System

***Strengths and weaknesses*:**

The Mental Health Division (MHD) is actively working to strengthen relationships with all stakeholders in the mental health system. Major partners include the Regional Support Networks

(RSNs), consumers, families, MHPAC, community mental health providers, state hospital patients, labor unions and allied systems. Some of these allied systems include formal systems such as the Children's Administration, the Aging and Disability Services Administration, the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, the Office of Superintendent of Public Instruction, the Department of Corrections, and the Division of Vocational Rehabilitation, to name a few. As noted earlier, with the reorganization initiated by the DSHS Secretary, greater inter-agency collaboration is expected.

Effective January 2005, a pilot project was initiated called the Washington Medicaid Integration Project (WMIP). Through this project, DSHS is working with Molina Healthcare of Washington, Inc (Molina) to manage and provide medical and chemical dependency services through Molina's provider network, with an initial enrollment of 6,000 individuals in a county north of Seattle. The focus of this new project is to make available a care coordination model, which is a team of care coordinators who will work with the clients to help identify health issues early, help coordinate services, and help the client follow-through with prescribed treatment. Coordination of these services is expected to accomplish the following:

- Prevent unnecessary hospitalizations;
- Postpone placement in nursing homes;
- Eliminate duplicate prescriptions; and
- Prevent the use of emergency rooms for treating conditions that are more appropriately addressed in physicians' offices.

While WMIP is initially focused on integrating medical and substance abuse treatment, this pilot will be expanded to include individuals with mental illness, many of whom struggle with complex medical needs and substance abuse as well. Inpatient care related to mental illness will also be incorporated into the plan. Outpatient mental health services will be added later this year and will be provided through Molina's approved network of providers consisting of licensed community mental health agencies. Together, all participants in WMIP are working to streamline and enhance the quality of care for Medicaid recipients enrolled in the pilot.

In addition to building upon the formal system infrastructure above, the use of other community resource programs to strengthen and diversify the community mental health system are frequently utilized such as churches, food banks, homeless shelters, the YMCA and YWCA. The mental health system also relies on natural support systems such as friends and neighbors through the use of Individually Tailored Care Plans which are consumer focused, strengths-based and needs driven.

Consumers and their families are also represented on a variety of MHD advisory groups and provide direction and feedback regarding the mental health system. One main avenue for consumer voice at the MHD, in addition to the MHPAC, is the MHD Office of Consumer Affairs (OCA).

OCA meets the requirements described in the MHD managed care waiver from the Centers for Medicare and Medicaid Services (CMS) and serves as an "independent" but internal component

of MHD's Management Team, reporting to the Director's Office. OCA provides MHD staff and MHBG contract holders with liaison and consumer-run advocacy and support services. While OCA is actively involved in the State Behavioral Health Conference, trainings for Ombudsmen and Quality Review Teams, as well as resolutions of consumer complaints at the Division level, its primary program is the "ORCA Conference Series" (Outreach, Recovery, and Consumer Advocacy).

ORCA is used to provide outreach and education services, while at the same time being utilized as a mechanism for voice collection through major conference events in each state region. Topics are consumer driven and follow the advocacy recommendations of CMS evaluations and MHD Quality teams.

In addition to supporting consumer education, research, and solutions, OCA also facilitates a Consumer Roundtable, which is an open membership "Client and Family Voice Network". The Roundtable's membership has grown to include over 2,000 consumers and supports a statewide open access web-platform database which catalogues a wide variety of experience, knowledge, and research provided by consumers. The Roundtable is designed to be utilized by MHD staff, RSNs and providers. Collectively, all of these OCA venues provide direct input for the Division's Director and are highly valuable.

Consumer training and employment is also possible through a newly implemented comprehensive training and certification program for Peer Counselors. To fully integrate this service, the State's Medicaid Plan was recently amended to allow peer support as a billable treatment modality under the Medicaid State Plan. To be accepted for the MHD-sponsored training, an individual must self-identify as a consumer of the public mental health system with one year in recovery.

The term, "consumer" is defined in the Washington Administrative Code and includes the parents or legal guardians of children under the age of 13 when they are involved actively in the treatment of the child. Individuals applying for certification must be registered counselors with the Department of Health, must successfully complete forty hours of in-class training that is experiential and informational in format and the individual must pass an oral exam and a written exam. Accommodations are provided for individuals with special needs and every opportunity is provided to enhance the success of the participants.

Upon completion of the requirements for peer counselor based on the Medicaid State Plan, a letter of completion is issued by the MHD verifying that the minimum qualifications have been met. Licensed community mental health agencies are beginning to hire and employ peer counselors to meet the requirement that all state plan services be available based on medical necessity. MHD anticipates expansion of peer support by continuing the trainings in the upcoming year and by enhancing an internet site devoted to this model of care focused on recovery and resiliency.

MHD staff members meet regularly with RSN administrators and assure that there is representation from the RSNs on any committee established to create or establish policy. These

committees also include providers, consumers, parents and family advocates and at times, allied system partners. Topics for discussion range from the call for evidenced based practices to the need for Washington Administrative Code changes.

MHD also meets with the Washington Community Mental Health Council, a provider group representing most of the community mental health centers that operate under subcontract with the RSNs to deliver direct services to consumers. MHD seeks and receives input as well from community mental health centers that do not belong to the council, but who subcontract with the RSNs.

As part of quality management, there have been three MHD sponsored System Improvement Groups, which have included consumers, parents, family advocates, community mental health centers, Washington Institute for Mental Illness Research and Training (WIMRT), and Regional Support Networks. System Improvement Group recommendations have been incorporated into the Division's quality management plan and into the activities of program planning, policy direction, and contract development.

MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee made up of providers from mental health, chemical dependency, other cross-systems and consumers. This group, having been in existence for approximately thirteen years, continually seeks to address the co-morbidity issues of mental illness and substance related disorders. The two divisions often engage in joint studies including developing a joint demonstration project serving persons with co-occurring disorders in Yakima.

Of significant note this year specific to co-occurring disorders, was the passage of the Omnibus Mental Health Reform Bill. This legislation lays the ground work for a truly integrated crisis system aimed at providing the right services to dually-diagnosed consumers in crisis as well as attempting to reduce hospitalizations and jail recidivism. Specific provisions include:

- Establishment of a process to identify individuals with co-occurring mental illnesses and substance abuse disorders through the consistent use of standardized screening and assessment processes;
- Expansion of the use of therapeutic courts (e.g.: drug, mental health and family therapeutic courts);
- Improvements in access to services by providing Medicaid processes so that someone released from jail or prison can have Medicaid benefits restored quickly so they receive the treatment they need to reduce the risk of re-offending;
- Improvements in access to inpatient services by creating a new facility licensure;
- Authorization for the creation of a combined mental and chemical dependency crisis response system in two pilot sites establishing secure detoxification facilities;
- Authorization for the creation of a combined mental and chemical dependency project to provide intensive case management services; and

- A mandate for the study of outcomes specific to both pilots.

Additionally, the State Legislature awarded $18.8 million dollars in state funds and $10.5 million in federal funds to more than double the chemical dependency treatment services to Medicaid-enrolled disabled adults.

As mentioned in Section I above which outlined the structure of the State's mental health system, the passage of House Bill 1290 is also seen as a new strength to our system. To briefly review, this bill allows, among other things, for the establishment of state-wide minimal criteria by which an RSN's qualifications will be evaluated, with potential for a procurement process. This change is expected to further enhance the provision of community mental health services.

With the passage of Substitute House Bill 1154, comes another significant move towards transformation. This legislation holds the requirement that insurance carriers in Washington State provide parity between mental health services and medical /surgical services. Specifically, co-payments, prescription drug benefits, out-of-pocket expenses, deductibles, and treatment limitations for mental health conditions must be the same as those for traditional physical health conditions. This is a significant step forward in strengthening the continuum of care, increasing access to mental health services, and facilitating recovery for thousands of Washington's residents who struggle with mental health issues, but for whom treatment has been beyond reach due to their financial limitations coupled with inadequate insurance coverage.

Another valuable tool for the enhancement of a comprehensive community based system of care is the Inpatient Roundtable, which is a technical assistance group comprised of staff from MHD, the Medical Assistance Administration, RSNs and community hospitals. This knowledgeable team meets on a routine basis to discuss various issues that arise relating to community inpatient services, working diligently to find reasonable solutions, while offering creative ideas for system improvement.

Other resources sought by MHD include SAMSHA grant funds awarded for the design and implementation of cross-system trainings with the Aging and Disability Services Administration. This was an annual $20,000 grant for three years beginning in 2001. Training has focused on residential providers and the development of cross-system crisis plans with multiple steps that can be utilized prior to calling the crisis line. Training also included presentations by individuals who have first-hand knowledge regarding local systems and provided direction on concerns such as when to call the crisis line and what to expect from them. MHBG funds were used to support this effort which also included training on the implementation and use of the evidence based practices of PEARLS (Program to Encourage Active Rewarding Lives for Seniors) and IMPACT (Improving Mood and Promoting Access to Collaborative Treatment) for late life depression. MHD will continue to actively enhance the outreach capacity and specialized services needed by this traditionally underserved population.

As a recipient of another SAMSHA resource called the Olmstead Grant, MHD is utilizing a collective $20K/year over a three year period to provide comprehensive training and support to the entire mental health system on the merits of implementing the evidence based practice of

Program for Assertive Community Treatment (PACT). In addition to the literature showing PACT as an effective mechanism for decreasing formal system utilization such as jails, emergency rooms, and hospitals, PACT programs have also proven highly successful in engaging some of the most ill consumers in our communities. Decreasing overuse of hospitals is not only the right thing to do, it is the prudent thing to do in terms of reducing Liquidated Damages, thereby increasing the funds available to the RSN's for direct services.

Also of interest to MHD is the fact that PACT can be implemented and provide positive outcomes in both rural and urban areas, which is a parallel to our population base. While 80% of the population resides on the Western half of the state, Washington has many rural areas within that populous as well as the on the less populated Eastern side of the state. Accordingly, MHD wants to encourage the use of this model as a viable resource for reduction of hospital utilization.

Even further demonstration of Washington's desire to promote use of evidence based practices has been MHD's contract with the Washington Institute of Mental Illness Research and Training (WIMRT) for the development and publication of an exceptional handbook titled, "Mental Health Best Practices for Vulnerable Populations", which includes, but is not limited to, evidence based practices for such traditionally underserved groups as sexual minorities, individuals with developmental disabilities, older adults, and individuals with diverse cultural issues such as Native American Tribes. This handbook has been provided to other states upon request in the service of technical assistance.

Specific to the latter, and considered a strength in our system, is the continuation of a Tribal Liaison position stationed at MHD to provide coordination with Washington's 29 federally recognized tribes in addition to three non-federally recognized tribes. Tribal members who are Medicaid enrolled retain the option to receive public mental health services through the RSNs or may choose to receive services through the tribal mental health system. The DSHS Administrative Policy 7.01 ensures MHD operates in a government-to-government relationship with the tribes. RSNs are also required to comply with the 7.01 Policy and must submit comprehensive plans to the MHD detailing tribal/RSN relations. A recent Memorandum of Understanding (MOU) was executed between DSHS and the Nisqually Tribe, recognizing the full faith and credit of tribal court orders for the first time. Other tribes have subsequently expressed interest in developing similar MOUs with DSHS.

Further enhancing Tribal/State relations was a Tribal Summit held two years ago, convened to focus on mental health issues. Active participants included members of various tribal councils, native healers and spiritual leaders as well as the Director of the MHD and other state employees. Tribal Summit work groups focused on ways to decrease disparities in access to services while increasing the quality of care for the State's Native American population.

In summary, some of Washington's strengths include:

- A dynamic, collaborative, and comprehensive infrastructure;
- A diverse and inclusive community support system;
- A cross-system, legislatively driven, new resource for co-occurring disorders including

crisis intervention and treatment through the Omnibus Bill;

- A dramatic change to Washington's mental health delivery system with the legislative mandate for a procurement process for the provision of services as well as legislation requiring mental health parity;
- A steady increase in consumer and family involvement in meaningful ways through MHPAC, Consumer Round Table, OCA, and the development of Peer Counselor Services, including provision for billing of Peer Counselor Services under the State Plan.
- A demonstrably clear and strong commitment to providing increased support and training for use of evidence based practices across all populations including children, older adults, other vulnerable populations, and otherwise difficult to engage adults with chronic and pervasive, severe mental illness;
- A coordinated dialogue and sincere efforts to improve relationships with and services to Washington's esteemed and diverse Native American Tribes; and
- An unwavering commitment to transformation, evidenced through MHD's Strategic Plan as well as this document.

While the community mental health system in Washington holds a strong and positive foundation, it is equally replete with opportunities for improvement, growth, and change as it faces considerable challenges related to all of the above.

For example, with the changes to our infrastructure comes the challenge of maintaining an undisrupted continuum of quality services and clear leadership as MHD is re-aligned with other Divisions. While MHD is expected to reap some benefits through this strategic reorganization, there is at the same time a call for a reduction in work force of 1,000 middle-management employees mandated by the Governor. These two efforts to streamline and improve the overall social and health system necessitate an increase in support to MHD staff in relation to their ability to "get the job done" and to not only maintain, but to move forward, the necessary business of public mental health in Washington. Considerable energy will need to be put forth to ensure that communication, cooperation, and collaboration are functional and meaningful during this process, as these will be paramount to successful transformation of the mental health system in Washington.

Also needing a high level of commitment and oversight is the implementation of the Omnibus Bill mentioned above which calls for, in addition to other items, the development of a cross-system co-occurring disorders pilot and an intensive chemical dependency case management pilot. Although the latter is primarily the responsibility of the Division of Alcohol and Substance Abuse, these resources are reflective of the service needs of many of our consumers. As such, provision of these services will need to be closely monitored for measurable outcomes to ensure effectiveness and sustainability. This will further require a knowledgeable MHD workforce with manageable workloads.

Finances are a pervasive issue in the provision of public mental health services. Overall funding within the mental health system has not kept pace with health care inflation in recent years. Funding increases due to rising Medicaid caseloads have been offset by reductions implemented in other areas for a variety of reasons. Although the legislature provided an unprecedented

amount of state-only dollars this budget cycle, a move which was seen as imperative to keeping the system whole, their doing so only maintains the previous funding levels and does not relieve the underlying issue: the mental health system in Washington State is under-funded. Accordingly, some Regional Support Networks have expressed concerns about whether or not they can continue to operate the mental health system in their catchment area. This is, of course, compounded by the legislative directives described above.

Because the community mental health system is funded under a capitation arrangement with county-based RSNs receiving monthly payments intended to cover the cost of providing mental health services in their catchment areas, funding provided is not identified to specific clients, nor is it targeted for certain services or programs. Rather, RSNs are directed to accomplish all of the requirements in the contract with the overall funding they receive.

Due to this broad provision of funding and vaguely defined outcomes, the Mental Health Division is often unable to clearly identify whether funds provided are sufficient to accomplish the goals set forth in statute, rule and contract. MHD is actively increasing the oversight and monitoring functions performed in an effort to ensure the delivery of quality mental healthcare that is focused on recovery and resiliency goals.

A significant concern is related to the system's dependency on the use of unspent Medicaid savings to provide services for non-Medicaid clients or to deliver services not covered by Medicaid. As of July 1, 2005, the state complied with a CMS directive to end this practice. While this decision lead to massive efforts to assess the service needs of non-Medicaid clients across the state and a coordinated movement to obtain the necessary state funds needed to cover those costs, Washington's need to diversify its resources and increase utilization of appropriate Medicaid funding remains focal. Basic changes to the manner in which Washington utilizes IMD settings and to the State's ability to provide other non-Medicaid services will need to occur for transformation to become reality.

As a result of participating in the Sixteen-State Pilot Indicator Project, the MHD is moving toward a performance and outcome-based system rather than one that emphasizes process. To prepare for this change, the MHD, RSNs, and providers have spent considerable time maintaining an updated data dictionary to improve data reporting. This shift may be hampered by new federal requirements placed on managed care entities as a result of the Balanced Budget Act (BBA) of 1997 and by some reporting requirements of the Health Insurance Portability and Accountability Act (HIPAA). These federal requirements were primarily implemented in SFY 2003; one pushing process, the other pushing outcomes. However, as they proceed, active planning, designing, training, adequate implementation time-lines and funding are required to ensure their success.

In summary, many of Washington's strengths serve also as our greatest challenges, begging for attention and resources to continue the efforts to improve services that are consumer based, accessible to all, and that are deeply rooted in the beliefs that everyone holds the ability to attain recovery and that everyone is resilient and possesses the right to have a meaningful life in their community.

Unmet Services & Critical Gaps:

As with most public mental health systems, Washington State struggles with having limited resources to meet the basic needs of its consumers. Recognizing this, MHD seeks creative ways to encourage the RSN's to address the call for recovery, not just maintenance, which unfortunately can be perceived as a message to "do more with less". As we move forward to implement the changes intended to promote greater consistency and more equitable access to high quality services, remaining aware of potential shortcomings within the system must be a priority as well.

With everyone involved from consumers and family members to the Governor, Washington has a reasonable grasp on where, in our continuum of care, chasms exist. While we are currently experiencing an unprecedented focus on the mental health system and the services provided therein, special attention will be devoted to the following fundamental items as we look to the future:

- Increased attention to residential supports, housing resources, and affordable housing to reduce homelessness and substandard housing for individuals with mental illness;
- Greater consideration to the process by which individuals who are eligible for Medicaid services can become recipients of such, allowing for increased access to not only mental health benefits, but to dental and medical services as well;
- Enhanced supports to help those consumers who want to work or go to school do so, as evidence shows that feeling productive and having purpose in one's life is critical to not only decreasing one's symptoms, but to making meaningful recovery a reality;
- Superior efforts to increase early intervention and prevention, cultural competency, and community education, thereby decreasing discrimination and stigmatization; and
- Expansive involvement of consumers in directing the mental health service delivery system in Washington, thereby providing them with what they say they need, when they need it, ultimately empowering them to take responsibility for themselves and realize their right to the pursuit of happiness.

Data Used to Identify Unmet Services and Critical Gaps:

All of the issues above have been unveiled through the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, as well as through the subjective input of MHD staff, the MHPAC, providers, and multiple other community organizations, and consumer/ family voice.

Plan to Address Unmet Services and Critical Gaps:

As articulated earlier, the MHPAC has worked diligently with MHD over the past year to revise our strategic plan, which is briefly outlined below. See attachment F for detailed goals and strategies.

The new strategic plan encompasses the issues highlighted above, providing the structure and foundation for our system's transformation based upon the New Freedom Commission's goals for transforming mental health care in America.

In an effort to encourage accountability and ensure the strategic plan remains a living document, the MHPAC has absorbed the annual tasks of reviewing the document against available data and then providing feedback to MHD. It is hoped that through this process, the Strategic Plan will be utilized as a highly valuable roadmap to system transformation.

MISSION STATEMENT:

"The Mental Health Division administers a public mental health system that promotes recovery and safety."

GUIDING PRINCIPLES/CORE VALUES

1. Promote the understanding that mental health is essential for overall health for all Washington residents.
2. Encourage consumers and families to drive the mental health care system, and be involved in program planning and their own recovery and resiliency process;
3. Provide persons with multiple-system needs with an integrated system of care through services that are delivered in community settings whenever possible, and eliminate disparities in mental health services;
4. Establish early mental health screening, assessment, and referral to services as common practice;
5. Utilize data to drive decisions to continuously improve health care services and accelerate research;
6. Require that business practices accommodate a changing environment, to include the use of technology to access mental health care and information.

***MHD's Future Vision for Adults*:**

It is the Mental Health Division's vision, held with clear determination, to transform mental health services in the State of Washington, enabling the promotion of real choices for real recovery. In accordance with the recommended changes outlined in the July 2003 Final Report of the President's New Freedom Commission on Mental Health entitled: "Achieving the Promise: Transforming Mental Health Care in America", coupled with the collective use of all available financial and human resources, MHD hopes to provide our citizens with the highest quality of mental health services available; services that are consumer driven, evidence based,

and outcome measurable.

Criterion 2: Mental Health System Data Epidemiology

Strengths and Weaknesses:

Like other states, Washington continues to struggle with ways in which data collection and utilization may be increased. Despite this, MHD has been successful in increasing the use of data for determining funding allocations, policy direction, and areas for future trainings. Hampering MHD's efforts in this area is a lack of adequate funding for data and research development, including programmatic and staffing shortages at MHD.

Regardless, MHD has made considerable progress in the system's ability to collect and use data that demonstrates the incidence and prevalence of serious mental illness (SMI) in adults and serious emotional disturbance (SED) in children. This is then followed by an increase in ability to turn that data into quantitative targets for system improvement. Some of the achievements and strengths with technology include:

- Maintenance of the MHD website with information on mental health treatment resources;
- Preparation by MHD of an annual Performance Indicator report, which is widely distributed to service providers, consumers, and family advocates. This is also shared with the MHPAC, allowing for well informed input by the Council and consequently serving as the driver for many MHD policy directions, proposed decision packages, and trainings.
- Creation by MHD of a web-based consumer outcome measurement system that provides real-time feedback to clinicians and consumers. These measures are also rolled up to both the agency and state levels to produce statewide indicator reports.
- Maintenance of a detailed data dictionary which is regularly updated by MHD.
- Participation in monthly meetings of a workgroup called the Information Systems Data Evaluation Committee, with members from MHD and RSNs, whose task is to review, evaluate, and recommend changes in the information system, including updates to the Data Dictionary.
- Collection and use of data derived from other sources such as the state hospitals and other state agencies such as the Medical Assistance Administration, the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, and Corrections. This data is integrated and available.
- Development of the ability to store data in a data warehouse for further analysis, research, and integration with other data sets.
- Completion of the first independent audit and report by an External Quality Review Organization (EQRO) as required under the BBA regulations for Medicaid Managed Care which includes an Information Systems Capability Assessment (ISCA) that noted no significant findings and further reported that the State system "was found to be stable and well run".

As indicated in our most recent Mental Illness Prevalence study, completed in 2000, the total

number of persons living with SMI/SED in our state is estimated to be 295,844, compared to the 1998 estimation of 157,969. Through combining the estimated number of adults with SMI living below the federal poverty level with the estimated number of children with SED living below the federal poverty level, the total number of persons likely to be dependent upon publicly supported mental health services is estimated at 148, 732. These numbers, along with the estimates of Medicaid enrollees per RSN, are useful in determining funding allocations for service provisions.

***Unmet Services and Critical Gaps*:**

While the use of the numbers indicated above is helpful in guiding policy and funding distribution, methodologies for the collection of data is in need of improvement. Some areas targeted for improvements include:

- Incompatible data interface systems between some RSNs and MHD;
- Inconsistent reporting by some RSNs on Performance Indicators; and
- Duplication of data collection efforts between state agencies.

Data Used to Identify Unmet Services and Critical Gaps:

All of the issues above have been identified through the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, as well as through the subjective input of MHD staff, the MHPAC, providers, and multiple other community organizations, and consumer/ family voice.

Plans to Address Unmet Services and Critical Gaps:

As indicated in Chapter 4 of the Strategic Plan in attachment F, MHD will continue with efforts to increase the use of technology and data in determining the future direction of public mental health services and system design in Washington. In addition to items articulated in the Strategic Plan, MHD is actively participating in several collaborative efforts with other DSHS Divisions to improve the process for acquisition of data to be used in future decisions.

MHD's Future Vision for Data Collection and Application:

Through the Medicaid Management Information System (MMIS), the use of the Data Infrastructure Grant (DIG), and the Medicaid Infrastructure Grant (MIG), the Mental Health Division intends to increase its ability to collect, analyze, and apply meaningful data for the development of future programs and policies for all the recipients of public mental health in Washington State. In accordance with goals articulated in the President's New Freedom Report's recommendations, MHD anticipates a steady increase in the use of data and research to drive the course of service provisions which will continue to lead to measurable and positive outcomes for our consumers.

Criterion 3: Children's System of Care

Strengths and Weaknesses:

In 2002, the Department of Social and Health Services formed a workgroup known as, "The Select Committee on Adolescents in Need of Long Term Placement' ("the Committee"), to examine the continuum of care and the sufficiency of services and housing options for youth with the most complex needs. The Committee has published a report that details the current status of services available for these children and makes strong recommendations for sweeping systems change, including adoption of Evidence Based Practices.

A DSHS Children's Mental Health Services Workgroup was convened in December 2003 by the DSHS Assistant Secretaries for the Children's Administration, the Juvenile Rehabilitation Administration, and the Health and Rehabilitative Services Administration, of which the MHD was a division. The Workgroup had thirty members, ten connected with each Administration, including field staff, providers, parents, foster parents, researchers, advisory board members, advocates, DSHS partners and other state agencies, meeting bimonthly through June. A report was presented to the three Assistant Secretaries at the end of July 2004 with recommendations for the improvement of mental health services and how they are delivered by DSHS. A SAMHSA System Improvement Grant was submitted to assist in the implementation of these reform efforts, but was not awarded.

As a result of this work group, and under the direction of the three DSHS assistant secretaries, the Children's Mental Health Initiative was born. As described above, this collaborative effort between the Mental Health Division, the Juvenile Rehabilitation Administration and the Children's Administration was formed to decrease duplication and increase resource management in an effort to provide more comprehensive services to children with SED and multi-system involvement.

One recent accomplishment of this group was the delivery of a report in February 2005 to the three DSHS secretaries, providing valuable research on evidenced based practices (EBPs) for children. In turn, five EBPs have been selected for broad implementation throughout all three systems. They include:

- Multi-dimensional Treatment Foster Care (MTFC);
- Functional Family Therapy (FFT);
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT);
- Family Integrated Therapy (FIT); and
- Multi-systemic Therapy (MST).

Implementation and delivery of services based on these EBPs are expected to generate treatment outcomes for children, youth and families which will hopefully result in placement stability, improved educational achievements, reduced out of home placements, reduced use of restrictive treatment options and overall improved quality of life and enhanced resiliency. The initiative will target implementation efforts by focusing on workforce development. By supporting

specialized training and certification for clinicians, significant work force enhancement can be achieved without disruption to usual funding levels and service priorities. A comprehensive implementation plan has been developed for each EBP with anticipated completion by the end of the biennium.

Another strength of Washington's mental health system for children is a joint project initiated by MHD with the Office of the Superintendent of Public Instruction. The goal of this endeavor is the identification of promising programs where public schools and public mental health providers may collaborate effectively. A report was subsequently submitted to the legislature in June of last year identifying 25 exemplary programs. Interviews and further information gathering took place last fall. Information about the promising practices identified will be disseminated through the public schools and public mental health systems within the coming months.

Unmet Services and Critical Gaps

While considerable progress continues to be made in many parts of our system, the following targets will require more work to be done to coordinate care across Washington's multi-service delivery system for children:

- Decreased utilization of inpatient care and juvenile justice system;
- Increased family involvement and empowerment;
- Increased community education; and
- Increased utilization of evidence based practices.

Through all of these efforts, the goal of MHD is to ensure that children with SED are treated, nurtured, and strengthened by the services that are provided to them so that they may know stability at home and school, enjoy better health and overall functioning, and ultimately come to realize their dreams, and those of their families', for a future rich in resiliency.

Data Used to Identify Unmet Services and Critical Gaps:

As indicated above, all of these issues have been identified through the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, other state agencies serving children, as well as through the subjective input of MHD staff, the MHPAC, providers, and multiple other community, consumer, and family voice.

Plan to Address Unmet Services and Critical Gaps:

Please refer to the Strategic Plan in attachment F for a more comprehensive description; in short however, MHD anticipates continued and unfailing dedication in the provision of mental health services, across all service arrays, to those children who struggle with SED (as well as their families) who reside in our state.

***MHD's Future Vision for Children's Services*:**

Children *are* our future, and as such, they have an inherent right to experience an environment wherein everyone works collaboratively to ensure their well-being and their development as healthy and happy individuals. The Mental Health Division is committed to the philosophy that everyone deserves a life in the community worth living. Accordingly, the Division goal is to see that children with SED are wholly supported, with all available resources, to become contributing members of society, where they can live, learn, and grow to their fullest potential.

Criterion 4: Targeted Services to Rural and Homeless Populations:

Strengths and Weaknesses:

Through utilization of funds received from Projects for Assistance in Transition from Homelessness (PATH), the Mental Health Division has made considerable in-roads to improving outreach, access, and outcomes for homeless individuals with mental illness.

In support of PATH, MHD used block grant funding aid in the production of two facilitated planning sessions for two regional support networks that were interested in improving their ability to serve homeless people. The RSNs worked collaboratively, enlisting the involvement of mental health providers, social service agencies, police officials, and other allied providers to attend a joint planning. A facilitator from a well known state housing organization assisted participants to accomplish the following:

- Review current capacity to serve homeless individuals with mental illness;
- Project additional capacity to be attained; and
- Consider strategies to close the gap.

The facilitator provided pre-meeting support and a written report, which included options and recommendations for obtaining additional housing and other needed services. Previous RSNs that have received this technical assistance have become PATH providers or have acquired significant additional housing stock and have put supportive services in place for homeless individuals with mental illness.

Another resource for PATH workers came through a conference which MHD co-sponsored with the Coalition for the Homeless. This was a highly successful event, providing resources, education and encouragement to this dedicated workforce.

In March 2005, a two-day training session was held for providers and allied partners who serve homeless, mentally ill people. The training focused on expediting access to SSI and SSDI benefits. National trainers, sponsored by CMHS, provided two single-day trainings, one focused on direct service providers and the other focused on managers and administrators at a systems level. Participants both days included representatives from the mental health and substance abuse service delivery systems, administrators from the corrections system, staff from the state

hospitals and the Taking Health Care Home project, staff from state and federal benefits offices, as well as PATH providers. Approximately 56 people attended.

In addition to the services supported through PATH, MHD continues to both provide technical assistance to and facilitates planning sessions with Regional Support Networks, community mental health agencies, local housing, and other service providers in an effort to improve community outreach and decrease homelessness for individuals with mental illness. The intensive planning involves an assessment of the current levels of housing and support services for individuals who are struggling with homelessness, mental illness, and substance abuse. Local participants then determine targets for improvement. Finally, the technical assistance provider assists in identifying viable strategies to meet these targets.

An anticipated result of this technical assistance is the increased collaboration among RSNs and providers with housing and other allied providers. Other outcomes of this training, in addition to a local plan to promote development of safe and affordable housing for citizens with mental illness and homeless individuals, is an overall increase in supportive and ancillary resources for these individuals, which in turn promotes greater housing stability.

Living outside of urban areas can prove very challenging when it comes to accessing treatment, with the barriers being not only such obvious needs as transportation and treatment availability, but also more discrete issues such as increased isolation and a culture of intense privacy.

Some of the ways in which MHD has addressed the need for rural outreach has been through supporting training activities on the specialized needs of consumers in these less populated areas. Additionally, RSN's have been required to ensure rural services are provided to a minimum of 25,000 individuals.

For individuals with mental disabilities who are homeless and for those who reside in rural areas, the frequent common denominators are often a lack of both personal support and quick access to services. While Washington continues to make strides in meeting the needs of these individuals, there remains an immense potential and sincere desire for improvement.

One agency, supported through MHBG funding, that has demonstrated success in outreach and engagement of homeless individuals with mental illness is the Downtown Emergency Services Center (DESC), which is located in the state's largest city, Seattle. DESC's mission is "to end homelessness of vulnerable people, particularly those living with serious mental or addictive illnesses."

According to DESC, the October 2003 "One Night Count" determined that nearly 2,000 people in Seattle alone were identified as being homeless, 40 percent of whom were children. The DESC believes this number, as large as it is, is a significant under-estimate of the city's homeless population as many people are typically undiscovered and therefore not counted. They also report that of those served by their agency over the past year, 82 percent experienced mental illnesses, 61 percent struggled with chemical dependency issues, and 35 percent were physically or developmentally disabled.

Further reported by the staff at DESC is the fact that most of the individuals they serve are disenfranchised from their communities, are isolated and are estranged from their families or natural supports, and are therefore lacking in the capacity to access services for which they are eligible. Accordingly, they frequently prove difficult to engage in treatment and often fade back into a painful state of non-existence. It is only through the individual support and comprehensive care of staff at the provider level, with support from the RSNs and the Division, that these individuals begin to have hope for recovery. MHD is proud to report the work of DESC and hopes to promote expansion of such quality programs in meeting the needs of this target population.

Although this is just one program in one city, the problem of homelessness amongst those with mental disabilities exists throughout the state. The Division ultimately supports diminishing homelessness into extinction.

Specific to rural services, Washington is somewhat unique. As described in Section 1 above, 80 percent of Washington's residents live on the Western half of the state, with the remaining 20 percent residing in the Eastern half. The latter is much more rural, possessing vast areas of farmland and desert. Despite this population density disparity, Western Washington also has many rural areas. In reality, the challenge of providing services to our rural residents is actually a state-wide issue.

Unmet Services and Critical Gaps:

Washington has made significant progress in providing services to homeless and rural consumers. Areas for future focus include:

- Increased education and training related to the special needs of these two populations and improved methods of engagement in treatment;
- Increased efforts to train providers on how to better assist these individuals in accessing the services for which they are eligible, such as Medicaid and Social Security Disability; and;
- Increased demands for measurable outcomes that demonstrate consistency across population densities.

Data Used to Identify Unmet Services and Critical Gaps:

All of the issues above have been identified through the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, homeless counts as well as through the subjective input of MHD staff, the MHPAC, providers, and multiple other community, consumer, and family voice.

Plan to Address Unmet Services and Critical Gaps:

As referenced in our Strategic Plan, MHD anticipates continued support of programs that have a proven, measurable success rate in engaging underserved populations. We anticipate ongoing use of PATH funds and other resources to train and support providers in effective means of engagement and resource acquisition for homeless persons struggling with severe mental illness and addiction. These efforts are expected to lead to an increase in accessible services across all life domains.

MHD's Vision for Future Services to Rural and Homeless Individuals:

The problems of homelessness and rural isolation are a national concern; certainly not limited to Washington State. However, Washington's MHD hopes to make a significant impact on the provision of services to these populations on a personal, local, regional, and state level as every resident in our state matters. Washington envisions a future wherein everyone who needs public mental health services is counted, engaged, and supported, rather than unseen, given up upon, or just plain "out of luck" because they live one place instead of another.

Criterion 5: Management Systems

Strengths and Weaknesses:

Approximately seventy people are employed within the Mental Health Division headquarters. It is from the Division headquarters that the following activities originate, the depth and breadth of which serve as both our strengths and our weaknesses:

- Coordination of state mental health policy and advocacy for a system that promotes prevention, hope, recovery, and culturally competent care;
- Accountability to the legislature for the public mental health system, which includes responsibility for licensure and certification processes, quality management, and the setting of policy and statute;
- Oversight of two primary service contracts: Medicaid and non-Medicaid (or "state-only").
- Management of two adult state psychiatric hospitals and one child psychiatric hospital (which collectively have approximately 2,7000 employees);
- Collaboration with other state agencies for the integration of consumer services across the entire social and health system;
- Reception and incorporation of consumer, family, and advocate voice in MHD business; and,
- Maintenance of a multitude of other administrative functions too numerous to outline.

Unmet Services and Critical Gaps:

Staffing levels and the structure of the Mental Health Division are expected to change significantly secondary to several mitigating factors:

- Under the recommendation of the Mental Health Task Force, MHD established an

independent contract to determine MHD readiness for procurement as well as to assess general functions and ways in which work should be delegated. The results of that report, called the Mercer Study, indicate a marked need for increased staffing at the Division headquarters to accomplish the work at hand. Additionally, the study recommended several changes within the organizational structure.

- In an effort to reduce expenditures, Governor Gregoire has mandated a reduction in force (RIF) of 1000 middle-management employees across all state agencies. The Department of Social and Health Services, of which MHD is a division, is expected to decrease its staffing by 330. MHD's assigned reduction requirement is 19 positions which include the two state hospitals. At a recent MHD staff meeting, DSHS Secretary, Robin Arnold-Williams, indicated she is aware of both the recommendations of the Mercer Study and the Governor's mandate. While she indicated uncertainty as to how she may address the disparity, she reported that she retains some flexibility in meeting the RIF requirements by determining how many reductions to require in each administration which could allow an administration to reduce further in order to allow MHD to increase staff support.

- With an expectation of streamlining the DSHS performance and accessibility to services for our state's residents, Secretary Robin Arnold-Williams has announced a plan to reorganize parts of DSHS. As such, MHD will be re-aligned with two sister agencies: the Medical Assistance Administration (MAA) and the Division of Alcohol and Substance Abuse (DASA) under a new administration called the Health and Recovery Services Administration (HRSA).

- Through the passage of recent legislation, Washington State is aware that changes may occur within our community mental health structure. Presently, there exist 14 Regional support Networks (RSN's) operating within our state. However, new legislation may lead to a reduction in that number due to the legislatively mandated Request for Qualifications (RFQ) process which is restricted to current RSNs. The possibility exists that fewer than all 14 RSN's will be able to meet the requirements of the (RFQ). If that occurs, that region will then be open to competitive bid through a Request For Proposals (RFP) process. This could lead to another RSN or managed care entity providing services to that region.

Because of the unique transitory position of the state as outlined above, Washington's MHBG Plan will likely be modified once the procurement process concludes and the geographical boundaries and organizational entities are determined.

Plan to Address Concerns for Management Systems:

We are in the midst of significant system transitions related to staff reductions, profound legislative actions, a new Governor, re-alignment with other state agencies, and internal re-organization, all of which are accompanied by uncertainty as well as anticipation. As such, it is with intention that Washington is submitting a MHBG plan that is similar to last year's plan. Additionally, this plan is for one year as MHD expects to move forward confidently with focused

efforts to utilize our MHBG funding on the facilitation of transformation.

MHD's Vision for the Future:

For the Division:

- Continued efforts to increase expertise of a highly skilled workforce within MHD;
- Stability of hierarchy, cohesion of merged divisions, and staffing at adequate levels to accomplish the exceptionally challenging and important work that lies before the Division.
- Expansion and inclusion of consumer and family voice in Division efforts to guide the mental health system toward greater alignment with the over-arching goals of the President's New Freedom Commission recommendations (outlined in the Executive summary of this document) for improvements to the service delivery system.

For the State Mental Health System:

- Care that is based in recovery and resiliency;
- Housing that is safe and affordable;
- Vocational opportunities that are meaningful and feasible;
- Services that are culturally competent and accessible to all who are eligible;
- Access to evidence based practices and services that are cohesive and well coordinated, demonstrating enhanced relationships between state agencies, RSN's, providers, Tribes, consumers, families, and communities, thereby facilitating a seamless continuum of care for recipients of mental health services in Washington State.

To achieve these goals, MHD will continue to focus its resources on the fundamental and imperative goal of ***transformation***. Accordingly, in determining how MHBG funds are utilized, the Division intends to use the six guiding principles below in determining how this valuable resource is spent:

Proposed expenditures for MHBG funding would be considered ideal if found to:

1. Be in concert with the National Outcome Measures and fall within the parameters of the MHBG assurances and requirements;
2. Work in tandem with the Division's Strategic Plan which, again, has been updated in collaboration with the MHPAC to incorporate the ideals of "Achieving the Promise: Transforming Mental Health Care in America";
3. Hold meaningful and measurable outcomes that are in line with articulated consumer/family voice;
4. Link well to other resources and transformation activities;
5. Meet needs in the system that are not fulfilled elsewhere, allowing for minimal negative impact on other service agencies if funding is not approved; and
6. Align well with other Division initiatives or legislatively mandated expectations.

SECTION III – Performance Goals and Action Plans to Improve the Service System

CRITERION 1: Comprehensive Community-Based Mental Health Plan

Goal 1 Increase Access to Services - Adult

Individuals have access to a system of comprehensive and integrated community based services.

Objective 1: Increase access to services for adults

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 1.5 % for adults who received publicly funded outpatient mental health services**.** **(Basic Table 2a)**

2002: 2.1 % (Achieved)
2003: 2.2% (Achieved)
2004: 2.1% (Achieved)
2005: Not available at this time
2006: 2.3% (Planned)

North Sound RSN will provide community support services for persons who are not eligible for the Medicaid program.

Peninsula RSN will provide flexible services and supports to increase community-based services for non-Medicaid consumers.

Objective 2: Provide seamless discharge from inpatient services

***Performance Indicator*:** Regional Support Networks will maintain a percentage of clients over 30% who received outpatient services within 30 days after being discharged from the state hospital, community hospital, or freestanding evaluation and treatment facility.

2002: 45.9% (Achieved)
2003: 58.2% (Achieved)
2004: 55.8 % (Achieved)
2005: Not available at this time
2006: 55.5% (Planned)

Objective 3: Increase access to services for American Indians

Performance Indicator: Maintain a statewide penetration rate of at least 2% for American Indian persons who received publicly funded outpatient mental health services. **(Basic Table 2a)**

2002: 4.7% (Achieved)
2003: 3.9% (Achieved)
2004: 4.2 % (Achieved)
2005: Not available at this time
2006: 4.5% (Planned)

The MHD will provide funding to support tribal and intertribal projects promoting culturally relevant and culturally accessible mental health activities for American Indians, Alaskan Natives, and their communities.

North Sound RSN will provide community support services for American Indian consumers who are not eligible for the Medicaid program.

Objective 4: Increase access to services for ethnic minorities

Performance Indicator: Maintain a statewide penetration rate of at least 1.5% for ethnic minority persons who received publicly funded outpatient mental health services**. (Basic Table 2a)**

2002: 2.09% (Achieved)
2003: 2.1% (Achieved)
2004: 2.2 %
2005: Not available at this time
2006: 2.3% (Planned)

North Sound RSN will provide community support services for ethnic minority consumers who are not eligible for the Medicaid program.

Performance Indicator: The MHD will support an annual consumer forum to promote ethnic minority consumer involvement in systems change and to support research on promising practices and the delivery of effective community based services to ethnic minority populations.

2005: Not available at this time
2006: Planned

Objective 5: Increase access to services for older adults

Performance Indicator: Regional Support Networks will maintain the proportion of older adults (60+ years) who received publicly funded outpatient mental health services at a rate greater than 1% of the general population. **(Basic Table 2a)**

2002: 1.4% (Achieved)
2003: 1.4% (Achieved)
2004: 1.3 % (Achieved)
2005: Not available at this time
2006: 1.5% (Planned)

King County RSN will maintain a Geriatric Regional Assessment Team to provide specialized, out-of-facility crisis services to older adults.

North Central RSN will provide services to older adults who are not eligible for the Medicaid program.

North Sound RSN will provide services for older adult consumers who are not eligible for the Medicaid program.

Peninsula RSN will provide outreach mental health services to older adult consumers who are not eligible for the Medicaid program.

Objective 6: Support training on the specialized needs of older adults

Performance Indicator: The MHD will support conferences and trainings with at least 20 participants at each event on the specialized needs of older adults consistent with evidence-based practice approaches.

2005: Achieved
2006: Planned

Objective 7: Increase access to services for sexual minorities

Performance Indicator: Provide mental health services and programs to a minimum of 1,500 adults who identify as sexual minorities.

2004: 1,731 (Achieved)
2005: Unavailable at this time
2006: 1,800 (Planned)

Performance Indicator: The MHD will support an annual "Say It Out Loud" conference co-sponsored with the Division of Alcohol and Substance Abuse to increase sensitivity on sexual minority issues.

2005: Achieved
2006: Planned

Objective 8: Increase access to services for adults with a developmental disability

Performance Indicator: Serve at least 3,000 persons with both a mental illness and a developmental disability in outpatient settings. .

2002: 3,309 persons, or 2.5% of persons served (Achieved)
2003: 5,582 persons, or 4.4% of persons served (Achieved)
2004: 5,567 persons or 4.2 % of persons served (Achieved)
2005: Not available at this time
2006: 3,700 (Planned)

Performance Indicator: The MHD will provide cross-system training on persons with a developmental disability to promote a highly skilled workforce current with best practices.

2005: Achieved
2006: Planned

Objective 9: Increase access to services for adults with a sensory impairment

Performance Indicator: Serve at least 1,000 persons with both a mental illness and a sensory impairment in outpatient settings.

2002: 1,662, or 1.3% of persons served (Achieved)
2003: 2,440, or 1.9% of persons served (Achieved)
2004: 2645, or 3.3 % of persons serviced (Achieved)
2005: Not available at this time

2006: 2,550 (Planned)

Objective 10: Increase access to medical services

Performance Indicator: Maintain a percentage of at least 70% of adult consumers who saw a nurse or doctor in the past year for a health check up or because they were sick.

2004: 88.9 %
2005: Not available at this time
2006: 89.0 % (Planned)

Objective 11: Increase access to dental services

Performance Indicator: Regional Support Networks will provide assistance to adult and child consumers to obtain state and federal entitlements (e.g. Medicaid).

2005: Not available at this time
2006: Planned

Goal 2: Reduce Utilization of Psychiatric Inpatient Beds – Adult

Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings.

Objective 1: Reduce unnecessary hospitalization

Performance Indicator: Regional Support Networks will maintain a percentage of adult outpatient clients who were not hospitalized at a rate over 80%.

2002: 93.5% (Achieved)
2003: 93.5% (Achieved)
2004: 93.8 % (Achieved)
2005: Not available at this time
2006: 94.0% (Planned)

Performance Indicator: Maintain a utilization rate of under 25 days per 1,000 population for clients admitted to community hospitals and freestanding evaluation and treatment facilities**.**

2002: 22.1 days per 1,000 population (Achieved)
2003: 21.2 days per 1,000 population (Achieved)
2004: 21.6 days per 1,000 population (Achieved)
2005: Not available at this time
2006: 21.0 days per 1,000 population (Planned)

Performance Indicator: Maintain a statewide rate of adults served in state hospitals not greater than 0.7 per 1,000 general population.

2002: 0.6 per 1,000 population (Achieved)
2003: 0.5 per 1,000 population (Achieved)
2004: 0.5 per 1,000 population (Achieved)
2005: Not available at this time
2006: 0.5 per 1,000 population (Planned)

Objective 2: Reduce rate of readmission to inpatient services

Performance Indicator: Regional Support Networks will maintain a percentage of under 5% of clients who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and who were readmitted to any of the inpatient settings within 30 days

2002: 3.9% (Achieved)
2003: 3.2 % (Achieved)
2004: 2.8 % (Achieved)
2005: Not available at this time
2006: 3.8% (Planned)

Performance Indicator: Regional Support Networks will maintain a proportion of persons served in community hospitals and freestanding evaluation and treatment facilities at a statewide rate not greater than 3.0 per 1,000 persons in the general population.

2002: 1.6 per 1,000 population (Achieved)
2003: 1.4 per 1,000 population (Achieved)
2004: 1.4 per 1,000 population (Achieved)
2005: Not available at this time
2006: 1.3 per 1,000 population (Planned)

Objective 3: Provide crisis intervention services

Performance Indicator: Regional Support Networks will provide crisis intervention services.

2005: Not available at this time
2006: Planned

Peninsula RSN will provide crisis services and programs intended to maintain community tenure and reduce hospital admission.

Objective 4: Develop residential alternatives to hospitalization

Performance Indicator: Regional Support Networks will provide services to at least 30% of their consumers in residential settings

2005: Not available at this time
2006: Planned

Pierce County RSN will provide Crisis Triage residential services as an alternative to hospitalization.

Goal 3: Implement Evidence-Based Practices

Implement Evidence Based Care statewide, to include reporting guidelines, fidelity assessments, incentives, increased monitoring of consumer outcomes, process for incorporation of new Evidence Based Practices.

Objective 1: Develop best practice resource guides

Performance Indicator: The MHD will support development of Resource Guides and

disseminate no fewer than 100 EBP Resource Guides in an effort to share information on evidence-based best practice models for engaging and serving mental health consumers.

2005: Not available at this time

2006: 125 (Planned)

Objective 2: Conduct research on emerging/promising practices

Performance Indicator: The MHD will support research on selected promising practices to support effective community based services and promote evidence-based practice.

2005: Planned

Objective 3: Support an annual statewide Behavioral Healthcare Conference

Performance Indicator: The MHD will provide support to the annual Behavioral Health Conference to promote a highly skilled workforce current with best practices including scholarships for consumers, parents and family advocates as evidenced by providing no fewer than 15 scholarships to these persons.

2005: 18 (Planned)

2006: 20 (Planned)

Objective 4: Provide training for consumers and family advocates

Performance Indicator: The MHD will contract with the Washington State chapter of the National Alliance for Mental Illness to provide outreach and educational programs, statewide information and referral, and advocacy effort for individuals with mental illnesses and their families.

2005: Planned

NEW Performance Indicator for 2006 instead of the previous one: MHD will instigate a Request for Proposals (RFP) and contract with selected entities to provide at least 4 trainings per year to consumers and their family members/advocates.

2006: 4 trainings (Planned)

Objective 5: Provide training for case managers and mental health professionals

Performance Indicator: The MHD will conduct training for case managers and mental health professionals, focusing evidence-based and promising practice models of service delivery.

2005: Not available at this time

2006: 30 CM's or MHP's will be trained with focus on EBPs (Planned)

Objective 6: Provide Mental Health Specialist training

Performance Indicator: The MHD will conduct training for mental health specialists, focusing evidence-based and promising practice models of service delivery.

2005: Not available at this time

2006: 20 MH Specialists will be trained with focus on EBPs (Planned)

Objective 7: Develop and support the use of Assertive Community Treatment

Performance Indicator: Number of persons receiving Assertive Community Treatment (ACT)

Services. **(Developmental Table 17)**

2005: Planned (Data collection through services reported with HCPC codes)
2006: Planned (Data collection through provider survey)

Objective 8: Develop and support the use of Family PsychoEducation

Performance Indicator: Number of persons receiving Multi-Family PsychoEducation Programs as part of an overall clinical treatment plan for individuals with mental illness. **(Developmental Table 17)**

2005: Planned (Data collection through services reported with HCPC codes)
2006: Planned (Data collection through provider survey)

Pierce County RSN will develop and support the use of illness self-management skills through the Pebbles in the Pond consumer/family education program.

Objective 9: Develop and support the use of Illness Self-Management Skills

Performance Indicator: Number of persons receiving a broad range of self-assessment and treatment skills to assist persons with a mental illness and their caregivers to assist consumers to be able to take care of themselves, manage symptoms, and learn ways to cope better with their illness. **(Developmental Table 17)**

2005: Planned (Data collection through services reported with HCPC codes)
2006: Planned (Data collection through provider survey)

Objective 10: Develop and support the use of Dialectical Behavior Therapy

Performance Indicator: Number of community mental health agencies implementing Dialectical Behavior Therapy (DBT) Programs.

2005: Planned
2006: Planned (Data collection through provider survey)

North Central RSN will provide Dialectical Behavior Therapy Team development and delivery of direct clinical services to non-Medicaid consumers.

Goal 4: Improve Client Perception of Care - Adult

Individual choice, satisfaction, safety, and positive outcomes are the focus of services.

Objective 1: Promote consumer satisfaction in service delivery

Performance Indicator: More than fifty percent of adults surveyed agree with the items on the MHSIP survey regarding their perception of the quality and appropriateness of mental health services provided. *This survey is conducted every other year*. **(Basic Table 11)**

2002: 77.1% (Achieved)
2003: Not available
2004: 76.7 % (Achieved)
2005: Not available
2006: 78.o % (Planned

Goal 5: Increase in Employment or Return to School - Adult

Support consumer recovery through employment and supported employment opportunities.

Objective 1: Increase consumer employment

Performance Indicator: Regional Support Networks will maintain a statewide percentage of at least 10% of adult outpatient service recipients between the ages of 18 and 64 years who were employed at any time during the fiscal year. (**Basic Table 4)**

2002: 13.0% (Achieved)
2003: 11.5% (Achieved)
2004: 9.6 % (Achieved)
2005: Not available at this time
2006: 12.0% (Planned)

Objective 2: Support consumer education opportunities

Performance Indicator: Regional Support Networks will provide supported education opportunities for a minimum of 20 consumers.

2005: Not available at this time
2006: 20 consumers (Planned)

Pierce County RSN will support consumer education and supported education activities.

Objective 3: Provide supported employment for consumers

Performance Indicator: Regional Support Networks will provide supported employment to at least 500 consumers. **(Developmental Table 17)**

2002: 784, or 0.6% of persons served (Achieved)
2003: 620, or 0.5% of persons served (Achieved)
2004: 1,233, or 0.9% of persons served
2005: Not available at this time
2006: 650 consumers (Planned)

North Central RSN will provide Career Path Services to provide pre-vocational and educational services to consumers.

Performance Indicator: Supported employment opportunities in state government will be provided to a minimum of 6 consumers.

2002: 12 (Achieved)
2003: 12 (Achieved)
2004: 12 (Achieved)
2005: Not available at this time
2006: 12 (Planned)

GOAL 6: Decrease Criminal Justice Involvement - Adult

Expand cross-system care coordination efforts within DSHS and the Department of Corrections

and other relevant agencies.

Objective 1: Decrease adult criminal justice involvement

Performance Indicator: Number of adults with a mental illness who had contact with the criminal justice system including arrest and incarceration. **(Developmental Table 19A)**

2005: Not available at this time

2006: Planned

Objective 2: Provide services to consumers released from the criminal justice system

Performance Indicator: Regional Support Networks will provide community mental health and other supportive services to assist consumers who have been released from the criminal justice system to successfully transition back into the community.

2005: Not available at this time

2006: Planned

King County RSN will provide services to support mentally ill offenders being released from state prisons in making a successful transition to the community.

Goal 7: Increase Social Supports - Adult

Support consumer clubhouses, implement peer support programs and certify Peer Counselors.

Objective 1: Support consumer clubhouses and drop-in centers

Performance Indicator: Regional Support Networks will provide support for consumer clubhouses and drop-in centers.

2005: Not available at this time

2006: (Planned)

Clark County RSN will maintain a consumer-run warm line operation and drop-in center.

Northeast Washington RSN will provide support for consumer drop-in centers.

Objective 2: Increase the number of peer support counselors

Performance Indicator: The MHD will provide specialized training to consumers so that they can become certified as peer support counselors.

2005: Not available at this time

NEW Performance Indicator for 2006 instead of previous one: MHD will provide specialized training to consumers resulting in the certification of at least 10 new peer support counselors.

2006: 10 (Planned)

Objective 3: Support the consumer Ombuds function

Performance Indicator: The MHD will provide training and support to RSN consumer Ombuds members.

2005: Not available at this time
2006: Planned

Goal 8: Increase Family Stabilization/Living Conditions - Adult

Services promote independent living through natural and community supports including family, friends, and other citizens.

Objective 1: Provide support for independent living arrangements

Performance Indicator: Maintain a statewide percentage of at least 60 % of adults and older adults who had an independent living situation as their primary residence at any time during the fiscal year.

2002: 56.3% (Achieved)
2003: 64.5% (Achieved)
2004: 63.8 % (Achieved)
2005: Not available at this time
2006: 65.0% (Planned)

Objective 2: Support consumer and family advocacy activities

Performance Indicator: Support consumer and family advocacy self-help, social activities, pre-vocational skill building and stigma reduction activities, which may also include funding to attend conferences, training and other mental health resource activities.

2005: Not available at this time
2006: Planned

Clark County RSN will contract with the local affiliate of the National Alliance for the Mentally Ill (NAMI) to provide education of consumers, families and the community based on the Crisis Intervention Team (CIT) training.

Goal 9: Adults with Co-Occurring Substance Use Disorders

Improve the delivery of services through an integrated approach to effectively respond to the special needs of adults with dual diagnoses.

Objective 1: Improve services to adults with Co-Occurring Disorders

Performance Indicator: Maintain a statewide percentage of mental health outpatient service recipients who had both a mental illness diagnosis and a substance abuse diagnosis and/or substance abuse impairment at a rate of at least 5%.

2002: 14.6% (Achieved)
2003: 15.4% (Achieved)
2004: 15.9 % (Achieved)
2005: Not available at this time
2006: 14.0% (Planned)

Performance Indicator: Maintain a percentage of at least 3% of mental health outpatient service recipients who also received services from the DSHS Division of Alcohol and Substance Abuse.

2002: 10.5% (Achieved)
2003: 10.4% (Achieved)
2004: Not available at this time
2005: Not available at this time
2006: 10.6 5% (Planned)

Performance Indicator: Maintain a percentage of at least 5% American Indian mental health outpatient service recipients who also received services from the DSHS Division of Alcohol and Substance Abuse.

2002: 9.4% (Achieved)
2003: 16.0% (Achieved)
2004: Not available at this time
2005: Not available at this time
2006: 11.0 % (Planned)

Objective 2: Provide integrated treatment for Co-Occurring Disorders

Performance Indicator: Regional Support Networks will provide dual diagnosis treatment for mental health and substance abuse interventions at the level of the clinical encounter. **(Developmental Table 17)**

2005: Planned

Peninsula RSN will provide integrated mental health/substance abuse treatment services to adults with co-occurring disorders.

Southwest RSN will provide integrated mental health/substance abuse treatment services to non-Medicaid consumers with co-occurring substance abuse disorders.

Objective 3: Support training on Co-Occurring Disorders

Performance Indicator: The MHD will jointly fund, plan, organize and offer annual co-occurring disorders conference with the Division of Alcohol and Substance Abuse to promote a highly skilled workforce current with best practices.

2005: Not available at this time
2006: Planned

Criterion 2: Mental Health System Data Epidemiology

This criterion provides an estimate of Washington State data on the incidence and prevalence of serious mental illness among adults and serious emotional disturbance among children and quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Adults (18 years and older)

Based on the prevalence estimates provided in the Federal Register, Vol. 64, No. 121 Washington State has an estimated 194,686 adults with serious mental illness (SMI). The

Mental Health Division (MHD) has used the guidelines set forth in the Federal Register, Vol. 64, No. 121 to estimate the number of clients in our service population who have SMI. The MHD operationalized the guidelines using diagnoses and the Global Assessment of Functioning (GAF). All diagnoses except substance abuse, development disorders, personality disorders, and dementia were used in the calculation. A GAF score of 60 or below was used as the functioning cutoff to determine SMI status. All numbers reported are based on data from fiscal year 2003

Table 1: SMI Estimates for Adults (18 years or older)

Estimated SMI	Total Adults Served	Estimated SMI Served	Quantitative Target
250,283	89,186	58,280	50,000

Children (0-17 years)

Based on the prevalence estimates provided in the Federal Register, Vol. 64, No. 121 Washington State has an estimated number of children with serious emotional disorders (SED) between 71,457 and 85,748. The Mental Health Division (MHD) has used the guidelines set forth in the Federal Register, Vol. 64, No. 121 to estimate the number of children in our service populations who have SED. The MHD operationalized the guidelines using diagnoses and the Children's Global Assessment Scale (CGAS). All diagnoses except substance abuse and development disorders were used in the calculation. A CGAS score of 60 or below was used as the functioning cutoff to determine SED status. All reported numbers are based on data from fiscal year 2003.

Table 2: SED Estimates for Children (0-17 years of age)

Estimated SED	Total Children Served	Estimated SED Served	Quantitative Target
94,279	37,704	26,891	20,000

Discussion:

The data presented here likely underreports of the number of adults with SMI and children with SED receiving services. The MHD has been collecting diagnosis and GAF and CGAS scores for a little over a year, and there is much missing data. This is impacting our ability to accurately determine the number of adults with SMI and children with SED. The table below shows the number of individuals where these elements are missing compared to the total served population. As data and reporting systems stabilize, reporting on the number of adults with SMI and children with SED who are receiving services will improve.

Table 3: Missing Data

Age Group	Total Served	Missing GAF/CGAS	Missing Diagnosis
Children	37,704	17,807	12,290
Adults	89,186	36,097	37,814

CRITERION 3: Child Mental Health Plan

Goal 1: Increase Access to Services – Children and youth

Individuals have access to a system of comprehensive and integrated community based services.

Objective 1: Provide community support services for children and youth

Performance Indicator: Regional Support Networks will maintain a percentage of at least 1% of children in the general population who received mental health services. **(URS Table 2a)**

2002: 2.4% (Achieved)
2003: 2.5% (achieved)
2004: 2.6% (Achieved)
2005: Not available at this time
2006: 2.6% (Planned)

North Sound RSN will provide community support services for children and youth who are not eligible for the Medicaid program.

Objective 2: Assure seamless discharge from inpatient services

***Performance Indicator*:** Regional Support Networks will maintain a percentage over 30% of children and youth who received outpatient services within 7 days after being discharged from an inpatient setting.

2002: 38.1% (Achieved)
2003: 46.7% (Achieved)
2004: 59.3% (Achieved)
2005: Not available at this time
2006: 47% (Planned)

***Performance Indicator*:** Regional Support Networks will maintain a percentage over 40% of children and youth who received outpatient services within 30 days after being discharged from an inpatient setting.

2002: 49.2% (Achieved)
2003: 57.4% (Achieved)
2004: 73.3% (Achieved)
2005: Not available at this time
2006: 56.5% (Planned)

Objective 3: Improve access to services for ethnic minority children and youth

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 25% for ethnic minority children who received publicly funded outpatient mental health services. **(Basic Tables 2a and b)**

2002: 34.6% (Achieved)
2003: 35.5 % (Achieved)
2004: 36.7 % (Achieved)

2005: Not available at this time
2006: 35.5% (Planned)

Peninsula RSN will provide services for Hispanic children and their families.

Objective 4: Improve access to services for American Indian children and youth

Performance Indicator: Regional Support Networks will maintain a statewide penetration rate of at least 3.5% for American Indian children and youth who received publicly funded outpatient mental health services. **(Basic Table 2a and b)**

2002: 4.1 % (Achieved)
2003: 3.8% (Achieved)
2004: 3.6% (Achieved)
2005: Not available at this time
2006: 4.1% (Planned)

Objective 5: Improve access to services for sexual minority youth

Performance Indicator: Regional Support Networks will provide mental health services and programs to more than 75 sexual minority youth.

2004: 132 (Achieved)
2005: 135 (Planned)

Goal 2: Reduce Utilization of Psychiatric Inpatient Beds - Children

Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings.

Objective 1: Increase community-based services

Performance Indicator: Regional Support Networks will maintain a percentage of outpatient children and youth who were not hospitalized at a rate over 80 %.

2002: 97.2% (Achieved)
2003: 97.6% (Achieved)
2004: 97.9% (Achieved)
2005: Not available at this time
2006: 98.0% (Planned)

Performance Indicator: Regional Support Networks will maintain a utilization rate of under 20 days per 1,000 population for children and youth admitted to a community inpatient setting..

2002: 13.3 days 1,000 population (Achieved)
2003: 12.7 days 1,000 population (Achieved)
2004: 12.5 days 1,000 population (Achieved)
2005: Not available at this time
2006: 13.1 days per 1,000 population (Planned)

Performance Indicator: Regional Support Networks will maintain a statewide rate of children and youth served in a state hospital or long-term inpatient programs at a rate that is not greater

than 30 per 1,000 general population.

2002: 24.3 per 1,000 population (Achieved)
2003: 24.5 per 1,000 population (Achieved)
2004: 22.9 per 1,000 population (Achieved)
2005: Not available at this time
2006: 23.5 per 1,000 population (Planned)

Objective 2: Provide crisis intervention services

Performance Indicator: Regional Support Networks will provide crisis intervention programs for children and youth as an alternative to inpatient services.

2005: Not available at this time
2006: Planned

Clark County RSN will provide crisis intervention programs to reduce the overall usage of community hospital beds for children.

Objective 3: Decrease rate of readmission to inpatient services

Performance Indicator: Regional Support Networks will maintain a percentage under **60%** of children and youth who were discharged from an inpatient setting, and who were readmitted to an inpatient setting within 30 days.

2002: 8.0 % (Achieved)
2003: 9.1 % (Achieved)
2004: 7.9 % (Achieved)
2005: Not available at this time

NEW Performance Indicator instead of previous one for 2006: Regional Support Networks will maintain a percentage under **10%** of children and youth who were discharged from an inpatient setting, and who were readmitted to an inpatient setting within 30 days.

2006: 10.0% (Planned)

Performance Indicator: Regional Support Networks will maintain a proportion of children and youth served in state hospital or CLIP settings at a statewide rate not greater than 0.5 per 1,000 persons in the general population.

2002: 0.1 per 1,000 population (Achieved)
2003: 0.1 per 1,000 population (Achieved)
2004: 0.2 per 1,000 population (Achieved)
2005: Not available at this time
2006: 0.2 per 1,000 population (Planned)

Goal 3: Implement Evidence-Based Practices – Children/Youth

Implement Evidence Based Care statewide, to include reporting guidelines, fidelity assessments, incentives, increased monitoring of consumer outcomes, process for incorporation of new Evidence Based Practices.

Objective 1: Develop and support the use of a WrapAround Process

Performance Indicator: Number of children and youth served through a WrapAround process.

2005: Not available at this time

2006: Planned (Data collection through provider survey)

Objective 2: Develop and support the use of Multi-System Therapy

Performance Indicator: Community mental health agencies will provide Multi-System Therapy programs.

2005: Not available at this time

2006: Planned (Data collection through provider survey)

Objective 3: Develop and support the use of Therapeutic Foster Care

Performance Indicator: Number of children and youth served in therapeutic foster care programs. **(Developmental Table 17)**

2005: Not available at this time

2006: Planned (Data collection through provider survey)

Performance Indicator: The MHD will plan and co-fund the annual Foster Care Conference to provide information on therapeutic foster care mental health services.

2005: Not available at this time

2006: Planned

Objective 4: Develop and support the use of Dialectical Behavior Therapy

Performance Indicator: Community mental health agencies will implement Dialectical Behavior Therapy (DBT) Programs.

2005: Not Available at this time

2006: Planned

Objective 5: Increase Parent Support and Empowerment activities

Performance Indicator: The MHD will support training, meetings, and special projects of the Statewide Action for Family Empowerment of Washington (SAFE-WA), Community Connectors, and other activities to improve parent support and empowerment.

2005: Not available at this time

2006: Planned

Goal 4: Improve Client Perception of Care – Children/Youth

Individual choice, satisfaction, safety, and positive outcomes are the focus of services.

Objective 1: Promote consumer voice in service delivery

Performance Indicator: More than 50% of youth and parent/caregivers surveyed agree with the items on the MHSIP survey pertaining to timely and convenient access to mental health services. *This survey is conducted every other year*.

2002: Not available

2003: 70.3% (Achieved)

2004: Not available
2005: Not available at this time
2006: Not available

Performance Indicator: More than 50% of youth and parent/caregivers surveyed agree with the items on the MHSIP survey regarding their perception of the quality and appropriateness of mental health services provided. *This survey is conducted every other year.*

2002: Not available
2003: 86.3% (Achieved)
2004: Not available
2005: Not available at this time
2006: Not available

Objective 2: Improve the delivery of services to American Indian children

Performance Indicator: More than 50% of American Indian youth and parent/caregivers surveyed agree with the items on the MHSIP survey regarding their perception of the quality and appropriateness of mental health services provided. *This survey is conducted every other year*.

2002: Not available
2003: 84.3% (Achieved)
2004: Not available
2005: Not available at this time
2006: 80% (Planned)

Objective 3: Improve the delivery of services to ethnic minority children

Performance Indicator: More than 50% of ethnic minority youth and parent/caregivers surveyed agree with the items on the MHSIP survey regarding their perception of the quality and appropriateness of mental health services provided. *This survey is conducted every other year*.

2002: Not available
2003: 87.4% (Achieved)
2004: Not available
2005: Not available at this time
2006: Not available

Goal 5: Increase Employment or Return to School – Children/Youth

Increase cross-system collaboration to help children and youth to achieve in school and employment.

Objective 1: Increase school attendance

Performance Indicator: School participation rate for mental health consumers. **(Developmental Table 19C)**

2005: Not available at this time

New Performance Indicator instead of previous one for 2006: Percentage of children/youth enrolled in mental health services who are currently attending school.

2006: 90% (Planned)

Performance Indicator: Number of children with satisfactory progress in school. **(Developmental Table 19C)**

2005: Not available at this time

New Performance Indicator instead of previous one for 2006: Percentage of children enrolled in mental health services with satisfactory progress in school as evidenced by having the equivalent of a "C" or "Satisfactory" rating average.

2006: 75% (Planned)

Objective 2: Support training on educational services for children

Performance Indicator: The MHD will support an annual early childhood conference to provide training on effective early intervention strategies, including services provided under the Individuals with Disabilities Education Act.

2005: Planned

Objective 3: Provide supported employment for youth

Performance Indicator: Over 25 youth with serious emotional disturbance will obtain supported employment positions.

2002: 73 (Achieved)
2003: 44 (Achieved)
2004: 36
2005: Not available at this time
2006: 45 (Planned)

Goal 6: Decrease Criminal Justice Involvement – Children/Youth

Expand cross-system care coordination efforts within DSHS.

Objective 1: Provide support to children in juvenile detention facilities

Performance Indicator: Regional Support Networks will provide services to children served by the mental health system who also have contact with the criminal justice system. **(Developmental Table 19B)**

2005: Not available at this time
2006: Planned

Pierce County RSN will provide support to children and youth in the Remann Hall Juvenile Detention Facility.

Objective 2: Provide services to youth released from juvenile justice facilities

Performance Indicator: Community mental health agencies will provide services to youth released from juvenile justice facilities.

2005: Not available at this time
2006: Planned

Goal 7: Increase Social Services and Supports– Children and Youth

Implement peer support, after-school social services and advocacy activities for children and youth.

Objective 1: Support youth advocacy and social services

Performance Indicator: The MHD will support youth advocacy, social services, pre-vocational skill building, self-help and stigma reduction activities, which may also include funding to attend conferences, training and other mental health resource activities.

2005: Not available at this time
2006: Planned

Objective 2: Increase the number of youth peer support counselors

Performance Indicator: The MHD will provide specialized training to youth so that they can become certified as peer support counselors.

2005: Not available at this time
2006: Planned

Objective 3: Provide after-school programs for children and youth

Performance Indicator: Community mental health agencies will provide after-school programs for children and youth.

2005: Planned

Goal 8: Increase Family Stabilization and Living Conditions

Services promote natural and community supports including family, friends, and other citizens.

Objective 1: Provide out of facility services for children and their families

Performance Indicator: Maintain a statewide percentage of at least 15% of children/youth under the age of 18 who received outpatient mental health services in the home, at school, or outside the mental health provider agency at any time during the fiscal year.

2002: 55.4% (Achieved)
2003: 47.2% (Achieved)
2004: 50.0% (Achieved)
2005: Not available at this time
2006: 50.10% (Planned)

Objective 2: Include family participation in discharge planning

Performance Indicator: Maintain a percentage of at least 60% of youth and caregivers served agreeing or strongly agreeing with the items on the MHSIP Youth/Family Survey – Participation in Treatment Scale. *This survey is conducted every other year*.

2002: Not available
2003: 68.1% (Achieved)

2004: Not available
2005: Not available at this time
2006: 68.2% (Planned)

Objective 3: Promote inter-system collaboration

Performance Indicator: A minimum of 200 children with serious emotional disturbance will be served by at least one other agency in addition to mental health.

Program areas	2002	2003
MHD and Juvenile Rehabilitation	251	234
MHD and Developmental Disabilities	794	700
MHD and Substance Abuse	842	899
MHD and Children's Services	11,394	11,356

2004: Not available.
2005: Not available at this time
2006: Planned

Objective 4: Support parent advocacy activities

Performance Indicator: The MHD will support parent advocacy, self-help, and stigma reduction activities, which may also include funding to attend conferences, training and other mental health resource activities.

2005: Not available at this time
2006: Planned

Peninsula RSN will provide funding for Parent Support and Empowerment – Bridges to Parent Voice programs.

Goal 9: Children/Youth with Co-Occurring Substance Use Disorders

Improve the delivery of services through an integrated approach to effectively respond to the special needs of children and youth with co-occurring disorders.

Objective 1: Increase services for children/youth with co-occurring disorders

Performance Indicator: Number of children with a co-occurring disorder who were served by the Mental Health Division and the Division of Alcohol and Substance Abuse.

2002: 6.5 %
2003: 6.6 %
2004: Not available at this time
2005: Not available at this time
2006: 6.8 %

Objective 2: Provide integrated treatment for co-occurring disorders

Performance Indicator: Number of children and youth receiving dual diagnosis treatment for mental health and substance abuse interventions at the level of the clinical encounter.
(Developmental Table 17)

2005: Not available at this time
2006: Planned

Performance Indicator: The MHD will provide annual statewide training on integrated mental health and chemical dependency treatment for children and youth.

CRITERION 4: Targeted Services to Rural and Homeless Populations

Goal 1: Improve Family Stabilization and Living Conditions

Increase the availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, including a full range of residential services and residential supports prescribed in the consumer's treatment plan.

Objective 1: Continue to support PATH programs

Performance Indicator: The MHD will apply for annual renewal of the Programs to Aid in the Transition from Homelessness (PATH) grant.

2005: Achieved
2006: Planned

Objective 2: Develop residential and housing capacity

Performance Indicator: The MHD will assess needs, set priorities, develop residential and housing capacity and increase cross-system collaboration.

2005: Not available at this time
2006: Planned

Objective 3: Provide ongoing support services to homeless persons

Performance Indicator: Regional Support Networks will maintain the statewide percentage of adult outpatient service recipients age 18 years and older who had an independent living situation as their primary residence at any time during the fiscal year at a rate greater than 60%.

2002: 56.3% (Achieved)
2003: 64.5% (Achieved)
2004: 63.8% (Achieved)
2005: Not available at this time
2006: 66.0% (Planned)

Performance Indicator: Regional Support Networks will maintain the statewide percentage of children/youth outpatient service recipients age 18 years and under whose primary residence was listed at any time as their own home, foster care, or “other” at any time during the fiscal year at a rate greater than 75%.

2002: 82.8% (Achieved)
2003: 85.8% (Achieved)
2004: 82.2% (Achieved)
2005: Not available at this time

2006: 84.2% (Planned)

Performance Indicator: Regional Support Networks will maintain the proportion of adult outpatient service recipients who were homeless at some point in time during the fiscal year at less than 15%.

2002: 6.0% (Achieved)
2003: 7.4% (Achieved)
2004: 6.5 % (Achieved)
2005: Not available at this time
2006: 8.0% (Planned)

Objective 4: Provide outreach services to homeless and at-risk youth

Performance Indicator: Regional Support Networks will serve more than 50 rural and homeless youth.

2002: 104 youths served (Achieved)
2003: 121 youths served (Achieved)
2004: 106 youths served (Achieved)
2005: Not available at this time
2006: 113 (Planned)

Objective 5: Provide support services for homeless children and their families

Performance Indicator: Regional Support Networks will maintain a statewide percentage of under 5% of children/youth outpatient service recipients whose primary residence was listed as homeless in the fiscal year and number of hours of service.

2002: 5.3% (Achieved)
2003: 1.6 % (Achieved)
2004: 1.5 % (Achieved)
2005: Not available at this time
2006: 2.0% (Planned)

Goal 2: Improve services to consumers in rural areas

Objective 1: Provide community-based services to consumers in rural areas

Performance Indicator: Regional Support Networks will provide services to a minimum of 25,000 persons in rural areas.

2002: 40,138 persons served; 774,952 service hours (Achieved)
2003: 55,577 persons, or 1,093,138 hours
2004: 57,024 persons, or 1,001,423 hours
2005: Not available at this time
2006: 46,000 (Planned)

Objective 2: Provide training on services to consumers in rural areas

Performance Indicator: The MHD will support training activities on the specialized needs of consumers in rural areas.

2005: Not available at this time
2006: Planned

CRITERION 5: Management Systems

MENTAL HEALTH DIVISION STAFFING

Goal 1: Support research and quality improvement activities

Objective 1: Convene statewide Quality Improvement Groups
Performance Indicator: The MHD will convene workgroups for the development of system change through statewide Quality Improvement Group activities.

2005: Not available at this time
2006: Planned

Objective 2: Support the Consumer Roundtable Committee
Performance Indicator: The MHD will provide support to the Consumer Roundtable as a forum to gather consumer voice from around the state and provide input for the development of system improvement.

2005: Achieved
2006: Planned

Objective 3: Conduct consumer/family satisfaction surveys
Performance Indicator: The MHD will contract with the Washington Institute for Mental Illness Research and Training to conduct a satisfaction survey of consumers and their families using the Mental Health Statistical Improvement Project (MHSIP). *Children/youth and adults will each be surveyed on alternate years.*

2005: Children (Achieved)
2006: Adults (Planned)

Objective 4: Support the Quality Review Team function
Performance Indicator: The MHD will provide training and support to RSN Quality Review Team members.

2005: Achieved
2006: Planned

Goal 2: Promote a highly skilled workforce

Objective 1: Provide training for providers of emergency health services
Performance Indicator: The MHD will provide community education on mental health and mental illness to providers of emergency health services, law enforcement and other first responders as evidenced by supporting Washington Association of County Designed Mental Health Professional (WACDMHP) conferences.

2005: Achieved

2006: Planned

Objective 2: Provide training on disaster mental health services

Performance Indicator: The MHD will provide training specific to emergency/disaster outreach services and the Crisis Counseling Program to assure improved coordination amongst disaster outreach workers so that those who individuals who are in need of additional mental health assessment and services are referred to appropriate resources.

2005: Not available at this time

2006: Planned

Objective 3: Provide training on vocational services

Performance Indicator: The MHD will support a vocational track at the Washington State Behavioral Health Conference providing training on best practices related to club houses, supported employment, and other related issues.

2006: Planned

Plan for expending the grant

FFY06 MHBG preliminary budget

Annual Estimated Grant Award		$	**8,400,033**
Grant Administration (5%)		**$**	**420,002**
Balance for RSN's and Other Activities		$	**7,980,031**
RSN's total (80% of the 95%)			
MIO Program		**$**	**451,000**
Contracted to Regional Support Networks		**$**	**5,933,000**
Other Plan Activities		**$**	**1,596,031**

Contracted to Regional Support Networks			
Chelan	1.30%	$	77,000
Clark	3.85%	$	228,000
Grays Harbor	1.31%	$	78,000
Greater Columbia	10.53%	$	625,000
King	29.69%	$	1,762,000
NE	1.05%	$	62,000
NC	3.52%	$	209,000
NS	11.23%	$	666,000
Peninsula	4.49%	$	266,000
Pierce	18.13%	$	1,076,000
SW	1.76%	$	104,000
Spokane	8.19%	$	486,000
Thurston	3.43%	$	204,000
Timberlands	1.52%	$	90,000
Total	100.00%	$	5,933,000

ATTACHMENTS

Attachment A: Funding Agreements

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2005

I hereby certify that WASHINGTON STATE agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2005, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and

21. The term State shall hereafter be understood to include Territories.

mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and

use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:
(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.
(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for

securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

(Signature on file) _____ _____
Governor
Christine O. Gregoire Date

Attachment B: Certifications

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION
2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS
3. CERTIFICATION REGARDING LOBBYING
4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)
5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

(Signature on file) _____

Secretary, Department of Social and Health Services Date

Robin Arnold-Williams

Attachment C: Assurances

NON-CONSTRUCTION PROGRAMS

(Signature on file)_____ _____
Secretary, Department of Social and Health Services Date
Robin Arnold-Williams

DISCLOSURE OF LOBBYING ACTIVITIES

(Signature on file)_____ _____
Secretary, Department of Social and Health Services Date
Robin Arnold-Williams

Attachment D: Planning and Advisory Council Bylaws

BYLAWS

of the

WASHINGTON STATE MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

MENTAL HEALTH DIVISION - DEPARTMENT of SOCIAL and HEALTH SERVICES
(06/30/05)

ARTICLE I: PURPOSE

Section 1: Name
The name of this unincorporated association shall be the Washington State Mental Health Planning and Advisory Council (WSMHPAC), throughout this document referred to as the "Council".

Section 2: Authority
Mental Health Planning and Advisory Councils (PAC's) exist in every state and U.S. Territory because of the passage of federal law 99-660 in 1986, continuing through Public Law 101-639 and Public Law 102-321 in 1992.

Through the authority of the Secretary of the Department of Social and Health Services (DSHS), a statewide citizen advisory council is established to aid the Mental Health Division (MHD) in its mission to assure that all persons regardless of race, ethnicity, disability, gender, age and sexual orientation experiencing mental illness can lead valued and satisfying lives in their communities.

Section 3: Goals
The Goals of the Mental Health Planning and Advisory Council shall be to transform the mental health system consistent with the goals of the President's New Freedom Commission on Mental Health, as follows:

G. Washington State residents acknowledge that mental health is essential to overall health.

H. Mental health care is consumer and family driven.

I. Disparities in mental health services are eliminated.

J. Early mental health screening, assessment and referral to services are common practice.

K. Excellent mental health care is delivered and research is accelerated.

F. Technology is used to access mental healthcare and information.

Section 4: Other Goals

F. Oversee the Federal Block Grant, including recommending the plan, amendments and reports submitted by the Mental Health Division to the Center for Medicaid and Medicare Services.

G. Develop and take advocacy positions concerning legislation, funding and regulations affecting mental health services through the use of mental health statistics for decision making and planning.

H. Support and advocate for quality, cost effective and individualized consumer/family based services through evidence based best practice models of care. Support research and use of promising practices through continuous quality improvement.

I. Promote optimal functioning for consumers across the life domains by removing barriers to services. The Council's focus will be education for children; supported employment for adults; and/or meaningful daily activities for older adults.

J. Support education about mental illness and other mental disorders in an effort to reduce stigma.

ARTICLE II: DUTIES

Section1: Duties

The Council will fulfill requirements of federal law 99-660 continuing through Public Law 101-639 and Public Law 102-321 which state that the Planning Council is expected to do the following:

1. To review the Mental Health Block Grant Plan and to make recommendations. The proposed plan must be submitted in writing to the members of the Council no less than thirty (30) days preceding the meeting in which the review is to take place.
2. To serve as an advocate for any person with a chronic or serious mental illness, children with a serious emotional disturbance, and other individuals with mental illness.
3. To monitor, review and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.

Section 2: Other Duties

1. To develop and take advocacy positions concerning legislation and regulations affecting mental health.

2. To exchange information and develop, evaluate and communicate ideas about mental health care.
3. To create and manage subcommittees as it may deem necessary to facilitate and inform.

ARTICLE III: MEMBERSHIP

Section 1: Qualifications

Membership criteria are guided by Revised Codes of Washington 43.20A.360 (RCW), Administrative Policy 2.10 and Public Law 102-321. Membership should:

A. Include a balanced geographic representation of race, ethnicity, disability, gender, age and sexual orientation.
B. Have a particular interest or expertise in mental health services.
C. Be interested in social service programs;
D. Be willing and able to commit to fully participate in all meetings and group activities during their term of appointment; and
E. Be willing to work toward success of the group.
F. Due consideration of federal mandates.

Section 2: Appointment of Members

The Secretary, upon recommendation of the Director shall appoint members of the Council.

Section 3: Membership

Membership shall not exceed thirty (30) members, nor consist of fewer than twelve (12) members. Consumer, family members and advocates shall represent at least 51% of the total members of the Planning Council.

A. Any individual or organization may submit an application for membership.
B. Membership will be configured to meet federal and state requirements, including balance of geographic, cultural and rural/urban diversity.
C. The ratio of parents of children with SED to other members of the Planning Council shall be sufficient to provide adequate representation of such children in the deliberations of the Council.
D. Nominations for membership will be reviewed by the Planning Council and, if approved, will be forwarded to the Director of Mental Health Division for review and recommendation to the DSHS Secretary.

E. All subcommittees will be represented on the membership of the Council by the Chair of the Subcommittee or a permanently assigned designee.

Section 4: Term of Membership

A. Members shall hold office for three (3) calendar years except in the case of a vacancy, in which event the appointment shall be only for the remainder of the unexpired term for which the vacancy occurs.

B. If approved by the Planning Council, a member may serve a second term. No member shall serve more than two consecutive terms. Eligibility to serve subsequently is regained after twelve months of absence as a member.

C. Vacancies shall be filled by the Secretary as they occur.

D. Members representing required state agencies do not have a term of office.

Section 5: Attendance at Meetings

A. Unless the Council determines otherwise, any member who has three (3) unexcused absences during a calendar year from regularly scheduled meetings shall be terminated from the Council's membership, and a vacancy shall be declared.

B. The Chair and Vice Chair will review the circumstances of members with three (3) excused absences in a calendar year and will submit a recommendation for action to the full Planning Council.

C. Prior notification of inability to attend shall be given not later than five (5) days before the meeting.

D. State agency and Council members who are unable to attend a meeting may send an alternate representing the same constituency who shall have the same rights and privileges as the Council member being represented. The alternate may cast a vote upon written appointment signed by the member.

E. A leave of absence may be requested and considered by the Council.

Section 6: Communication

Council communication during face to face meetings, emails and/or telephone conference calls shall follow these guidelines:

A. Be respectful of diverse opinion.

B. Be aware of confidentiality and personal privacy.

C. Be aware that ALL Council communication is in the public domain.

D. Only the Council Chair with Council approval will represent the Council

E. Mail and email lists will be limited to Council members.

F. Subcommittee chairs shall distribute information to subcommittee members and MHD staff.

Section 7: Other Requirements

A person may not be made an ex-officio member of the Council.

ARTICLE IV: MEETINGS

Section 1: Meetings

A minimum of eight (8) meetings will be held per year. Meetings are open to the public. Individuals may request being placed on the agenda.

Section 2: Individuals from the public may request to be placed on the agenda as "new business" for the next Council meeting subject to veto by the Council.

Section 3: Special meetings may be called by the chair or by the chair at the request of any member for the transaction of only such business as is stated in the call for the meeting.

Section 4: In the case of an emergency, action may be taken by the chair and vice chair by alternate communication concurrence by a majority of the members. Such action shall be noted in a special memo placed in the minute book and signed by the person obtaining such concurrence and shall be reported in the minutes of the next meeting.

Section 5: Agenda

A. Agenda items for meetings are to be submitted to either the Council Chair or to the program administrator assigned to staff the Council no later than ten (10) days before a scheduled meeting date.

B. Inclusion of any agenda item for a particular meeting will be determined jointly between the Chair of the Council and the program administrator.

C. Additional agenda items not previously scheduled may be submitted for consideration by the members at the beginning of each meeting and may be incorporated into the agenda at the direction of the Chair.

D. If time permits, the public may be invited to comment at the end of the Council's business.

Section 6: Decision Making Process

Decisions of the Council shall be preferably by consensus or, failing that, by majority vote of the members present.

Section 7: Quorum

A quorum shall consist of a simple majority of the appointed members/designee of the Council (50% + 1).

A. At meetings where a quorum is not present, the only actions that may legally be taken are to fix a time for adjournment, adjourn, recess, take measures to obtain a quorum (such as contacting absent members), and to determine the time for the next meeting.

B. The Chair (or his/her designee from the Council, if the Vice-Chair is not present) must be present in order to conduct business. These officers are members, and are counted in determining whether there is a quorum.

C. Members of the public are not counted in determining quorums.

Section 8: Rules of order

In all procedural matters not governed by these Bylaws, the Council shall be bound by the provisions of the 21st Century Robert's Rules of Order.

ARTICLE V: ELECTIONS AND OFFICERS

Section 1: **Election of Officers**

The Council shall elect from its membership a Chair and Vice-Chair. An election will be held at the November meeting (or December meeting in the event that there is no November meeting) to take office the following January.

A. Both Chair and a Vice-Chair will hold two-year terms with mandatory term limit of three consecutive full terms. Following a minimum of 1 year out of either office, following such term limitation, the person would become eligible again to serve in the same office. This does not preclude someone from serving in the other office upon reaching the term limit for one office.

B. Should someone take office to fill an unexpired term, they will serve until the end of the unexpired term and then may be elected to their first full term in either office.

C. The Chair shall vote whenever his or her vote will affect the outcome: to break or cause a tie; to block or cause attainment of a two-thirds majority when a two-thirds majority is necessary for an action pending.

Section 2: Removal

An officer may be removed by the Council whenever, in its judgement, the best interests of the Council would be served thereby, but such removal shall be without prejudice to such officer's position as a member. Any officer may resign at any time by giving written notice to the Council. Removal may occur only at the properly called meeting of the Council, after at least thirty days notice to the person proposed to be removed.

Section 3: Spokesperson for the Council

The Chair, or her/his designee from the Council, will be the spokesperson for the Council. When an individual Council member speaks or writes publicly, they must clarify that they represent themselves.

Section 3: Nominating Council

The Chair will appoint a three member Nominating Council at the August meeting to recommend candidates for nomination as Chair or Vice Chair

A. Each candidate must have agreed to have his/her name placed in nomination.

B. The names will be submitted by the Nominating Council at the November meeting. Additional nominations may be submitted from the floor.

ARTICLE VI: TRAVEL AND EXPENSES

Section 1: Reimbursement for Expenses

Expenses and reimbursement shall be consistent with WAC 43.03.050-060 and Department Policy.

A. Members shall be encouraged to use the least costly means of travel. Requests for travel arrangements must be made to the MHD at least two weeks prior to any regularly scheduled meeting.

B. Travel expenses for members employed by state agencies, provider agencies, and Regional Support Networks (RSNs) will be covered by those respective agencies.

C. Advisory Council members who work for agencies, which contract with the division, are responsible for their travel expenses.

Article VII: SUBCOMMITTEES

Section 1: Subcommittees

The Council is empowered to create and/or disband such Standing or Ad Hoc Subcommittees as it deems appropriate.

Section 2: Subcommittee Membership

The Council Chair or his/her designee shall be an ex-officio member of all Council subcommittees. The Chair of each subcommittee shall be recommended by the Subcommittee members and appointed by the Council Chair. The membership on such subcommittees shall be appointed by the Council Chair and confirmed by the membership of the Council on an annual basis. Subcommittee members shall serve at the pleasure of the Chair of the Council within the member's term of appointment and may include both Council members and non-members.

Section 3: Size and Terms of Appointment

Size of Subcommittees and Terms of appointment for members of subcommittees shall be as follows:

A. For Ad Hoc Subcommittees: the duration of the assignment to the subcommittee. as determined by the council. Ad Hoc Subcommittees shall be not less than three members. The Ad Hoc Subcommittee will generate recommendations for consideration by the Program/Planning Subcommittee and a vote by the full Council.
B. For Standing Subcommittees: three full calendar years with the possibility of reappointment for one additional term. Persons who have completed six consecutive calendar years of service on a given subcommittee may not be reappointed before the lapse of one full year following the expiration of their previous appointment. Standing Subcommittees shall have not less than 5 nor more than 15 members, including at least one council member.

Section 4: Subcommittee Meetings and Reporting

Standing Subcommittees shall meet a minimum of 4 times per year. Reporting from the Subcommittees to the Council shall be mandatory on a regular basis in a format and according to a schedule outlined by the Council Chair at the time of the subcommittee's establishment, or as may be modified in writing by the Council Chair from time to time.

Section 5: Standing Subcommittees

The following shall be Standing Subcommittees:

A. Legislative Subcommittee: to review and/or propose public policy and/or practice that pertain to access, treatment, rehabilitation, and reintegration of adults affected by serious mental illnesses and of children affected by serious emotional disorders, including recommending positions and actions on legislation, WACs, and MHD

contracts for consideration by the Council. This Subcommittee, if possible, should consist of one representative from each of the subcommittees specified in C, D, E and F of this section; one RSN representative; an expert in the subcommittee's focus; and a consumer advocate, assuring balanced representation from rural and urban areas. The Subcommittee shall work in concert with all Subcommittees utilizing the Council's communication protocols and will consult with the appropriate Subcommittees regarding issues pertaining to the populations they represent.

B. Program/Planning Subcommittee: to review, analyze, and evaluate the effectiveness based on costs and consumer outcomes of existing publicly funded policies and practices that pertain to access, treatment, rehabilitation, and reintegration of adults affected by serious mental illnesses and of children affected by serious emotional disorders, including recommending eliminations, expansions, and/or modifications for consideration by the Council. This Subcommittee, if possible, should consist of one representative from each of the subcommittees specified in C, D, E and F of this section; one RSN representative; an expert in the subcommittee's focus; and a consumer advocate, assuring balanced representation from rural and urban areas. The Subcommittee shall work in concert with all Subcommittees utilizing the Council's communication protocols and will consult with the appropriate Subcommittees regarding issues pertaining to the populations they represent. The Subcommittee will review Council nominations and make recommendations for a full Council vote.

C. Children's Treatment and Services Subcommittee: to focus primarily on the impact of legislation, public policies, and practices particularly on affected children and their families, including in institutional, residential facilities, and/or community settings. This Subcommittee shall inform other Subcommittees utilizing the Council's communication protocol and work in concert with the interested and appropriate Subcommittees in consideration of specific issues and shall develop/strengthen relationships between systems and promote cross-system sharing. This subcommittee will work in concert with the Legislative/Administrative and Program/Planning Subcommittees in developing their recommendations concerning such matters for the Council.

D. Sexual Minorities Treatment and Services Subcommittee: to focus primarily on the impact of legislation, public policies, and practices particularly on affected sexual minorities in institutional, residential facilities, and/or community settings. This Subcommittee shall inform other Subcommittees utilizing the Council's communication protocol and work in concert with the interested and appropriate Subcommittees in consideration of specific issues and shall

develop/strengthen relationships between systems and promote cross-system sharing. This subcommittee will work in concert with the Legislative/Administrative and Program/Planning Subcommittees in developing their recommendations concerning such matters for the Council.

E. Older Adults Treatment and Services Subcommittee: to focus primarily on the impact of legislation, public policies, and practices particularly on affected older adults in institutional, residential facilities, and/or community settings. This Subcommittee shall inform other Subcommittees utilizing the Council's communication protocol and work in concert with the interested and appropriate Subcommittees in consideration of specific issues and shall develop/strengthen relationships between systems and promote cross-system sharing. This subcommittee will work in concert with the Legislative/Administrative and Program/Planning Subcommittees in developing their recommendations concerning such matters for the Council.

F. Ethnic/cultural Minorities Treatment and Services Subcommittee: to focus primarily on the impact of legislation, public policies, and practices particularly on affected ethnic/cultural minorities in institutional, residential facilities, and/or community settings. This Subcommittee shall inform other Subcommittees utilizing the Council's communication protocol and work in concert with the interested and appropriate Subcommittees in consideration of specific issues and shall develop/strengthen relationships between systems and promote cross-system sharing. This subcommittee will work in concert with the Legislative/Administrative and Program/Planning Subcommittees in developing their recommendations concerning such matters for the Council.

Section 6: Removal

The Chair or any member of any Subcommittee may be removed for willful misconduct by a majority vote of a quorum of the Council at any time at a properly called meeting of the Council.

ARTICLE VIII: PUBLIC DISCLOSURE AND MEDIA RELATIONS

Section 1: Public Disclosure

All state agencies are required by RCW 42.17 to have available for inspection and duplication, public records such as procedural rules and statements of general policy. Certain personnel and financial records are exempted, such as employment records, financial or commercial information supplied to an investment board.

Section 2: News Media

The news media has the important function of informing the public about state government operations. In doing so, the media provides an important link with the community.

A. Individual Council members may speak publicly on any issue as private citizens.

B. The Department of Social and Health Services (DSHS) media relations staff is available to assist the Chair with media relations.

C. The Chair, or her/his designated spokesperson for the Council, is encouraged to consult with the Mental Health Division Director and DSHS media relations staff before any contact with the media.

ARTICLE IX: GRIEVANCES AND COMPLAINTS

Section 1: Grievances and Complaints by Council members and/or public

Any grievance and/or complaint is to be in writing stating the specific issue(s) and giving the fact(s) supporting the grievance and/or complaint. The Council Chair and /or Vice Chair will determine whether an Ad Hoc Subcommittee is established or the Mental Health Division Director is asked to be involved.

ARTICLE X: AMENDMENTS

Section 1 Amendments

Bylaws may be amended by a two-thirds majority of those present. The proposed revision must be submitted in writing to the members of the Council no less than ten (10) days preceding the meeting in which the vote is to take place.

Approved by vote of the Council:

Joanne Friemund (signature on file) _____

MHPAC Chair Date

Approved for the Mental Health Division:

MaryAnne Lindblad (signature on file) _____

MHD Interim Director Date

Attachment E: Mental Health Task Force Recommendations

Final MHTF Recommendations
December 8, 2004

Supplemental Budget

1. Recommend the Governor-Elect and the Legislature maintain current mental health services and funding levels through the end of the current biennium and a separate supplemental budget for community mental health services be introduced and passed on an expedited basis. DSHS should front-load current state-only dollars available through 2005 to be available for January expenditure, if necessary, for immediate backfill so that RSNs will not have to discontinue services.

2005-07 Biennial Budget

1. Recommend that the lost federal funds are replaced with state-only funds, to the maximum extent possible.

2. If additional state funding is made available, it should be used to address: (1) the lack of community residential and psychiatric inpatient beds as documented by the PCG report, (2) retaining existing community hospital and Children's Long Term Inpatient (CLIP) beds, and (3) meeting the need for forensic evaluations and beds.

Policy Changes

1. The Department of Social and Health Services should not close State Hospital beds until additional residential capacity is added in the community.

2. The Department of Social and Health Services should suspend, rather than terminate eligibility for Medicaid when an otherwise eligible person is confined in a correctional facility or is a resident of a state hospital. In addition, the Department of Social and Health Services should expedite Medicaid applications for persons with a mental illness being discharged from a state hospital or released from a correctional facility.

3. The Legislature should amend chapter 71.24 RCW to provide greater direction to RSNs regarding how state-only dollars will be used for non-Medicaid priority populations.

4. The Legislature should enact legislation authorizing the use of mental health courts state-wide.

5. The Department of Social and Health Services and Regional Support Networks should develop contingency plans for the potential loss of some or all of the state-only

backfill for the 2005-07 biennium.

6. The Department of Social and Health Services and Regional Support Networks should seek additional federal and private grant funds to support eligible programs.

7. The legislature should amend chapter 71.24 RCW to require the use of evidence-based practice in the treatment of mental illness and promote recovery from mental illnesses.

8. The legislature should continue the Joint Legislative and Executive Task Force on Mental Health Services and Financing into the 2005-07 biennium.

December 8, 2004

Attachment F: MHD Strategic Plan

As the entire Strategic Plan is quite large, we are only attaching Chapter 4 for reference

Chapter 4 ● Transformation Goals, Objectives, Strategies and Performance Measures

The Mental Health Division has set six transformation goals for 2006-2011:

1. Promote the understanding that mental health is essential for overall health for all Washington residents.
2. Encourage consumers and families to drive the mental health care system, and be involved in program planning and their own recovery and resiliency process;
3. Provide persons with multiple-system needs with an integrated system of care through services that are delivered in community settings whenever possible, and eliminate disparities in mental health services;
4. Establish early mental health screening, assessment, and referral to services as common practice;
5. Utilize data to drive decisions to continuously improve health care services and accelerate research;
6. Require that business practices accommodate a changing environment, to include the use of technology to access mental health care and information.

A. IMPROVE CLIENT HEALTH AND SAFETY – PUBLIC VALUE

Goal 1:

Promote the understanding that mental health is essential for overall health for all Washington residents.

Objective #1:

Actively promote recovery, resiliency and the reduction of stigma for persons experiencing mental illness across the life span.

Strategies:

- MHD will outreach and showcase clients' skills and abilities as a means of stigma reduction.
- MHD will provide opportunities to allow clients to tell share their stories of recovery with others.
- Develop advertisement campaigns promoting recovery and community support of persons in recovery from mental illness; clients involved in the design and implementation of campaign.
- Work with counties and agencies to promote recovery, resilience and the reduction of stigma through the mental health system.

- Create a recovery manual in collaboration with the Washington Institute similar to the domestic violence manual and distribute it throughout the system, including the Courts.
- Develop triage units and additional mental health courts created wherein persons with mental illness, when possible, will be diverted from the criminal justice penal system and will be assessed for treatment at the onset of involvement with the state to intervene and prevent incarceration.

Objective #2:
Require that all persons experiencing mental health issues be treated with the minimum standard of care equivalent to respect, understanding and compassion.

Strategies:
- Develop mission statements for persons working with the MHD and contract agents that incorporate the values of respect, understanding and compassion as fundamental in treatment of persons experiencing mental illness.
- Work with counties and agencies to promote these values.
- Adopt philosophies such as the Rochester New York Emotionally Disturbed Persons Response Team which makes every effort to preserve the dignity of every individual encountered who is emotionally disturbed or experiencing mental illness.
- Provide training for clinical providers to adhere to these minimum standards of treatment of respect, understanding and compassion.

Measures:

- Determine by survey or assessment the number of communications identifying the potential for recovery from all mental illness and increase that number by 20% each year.
- Determine by survey or assessment the number of detention centers and mental health facilities that are modeled after clubhouses and increase that number by 20% each year.
- Determine by survey or assessment the number of mental health facilities whose social environments are controlled or directed by psychiatry and reduce that number by 20% each year while maintaining the availability of psychiatric services for those who choose them.
- Determine by survey or assessment the number of brochures, and other informational sources for citizens interested in learning more about recovery and increase the number of people exposed to this new information by 20% each year.
- Determine by survey or assessment the number of persons experiencing mental illness who are treated within the criminal justice system and decrease that number by 20% each year until all persons experiencing mental illness are given the appropriate treatment over penalty.

- Determine by survey or assessment the number of persons experiencing mental illness who have employment, an independent living situation, social connectedness, substance use, contact with the criminal justice system and increase employment, independent living situations, social connectedness by 20% each year while reducing substance use and contact with the criminal justice system by 20% per year.
- Determine by survey or assessment the number of persons experiencing mental illness who have levels of self-esteem, hope, seeing themselves as worthwhile, and perspective and awareness of their "illness" and increase the number by 20% each year.
- Determine by survey or assessment the number of persons experiencing treatment with respect, dignity and compassion and increase that number by 20% until all persons are so treated.
- Determine by survey or assessment the number of persons who are allowed to direct their recovery treatment in a meaningful manner and increase that number by 20% until all persons are so treated.

B. IMPROVE CLIENT SELF-SUFFICIENCY – PUBLIC VALUE

Goal 2:

Mental Health care is client and caregiver driven, with clients, families, caregivers and advocates involved in individual recovery and resiliency process.

Objective #1:

Clients and family members direct their own recovery and resilience planning.

Strategies:

- Implement a resilience and/or recovery model whereby the client and their community of family or caregivers is the leader in determining items needed for their individual recovery and resilience plan.
- Develop an education and training program to assist care providers (to include primary care physicians) and clients in understanding resilience and recovery, and to ensure consistent use of words and meaning.
- Expand the information on SSDI, SSI, the Ticket to Work, Medicaid buy-in and other employment opportunities for adult consumers.
- Require the integral involvement of clients in the development of their recovery and resilience process.
- Increase programming and recreational activities for state hospital patients across the life span at all times to help patients maintain social, physical, and psychological well being.
- For long term patients, introduce skill building and work tasks to foster responsibility and self-esteem.
- Request revisions for Chapter 71.24, 71.34 and 71.05 RCW to reflect current program realities and to clearly state the rights of clients.

- Provide training to clients in the development of Wellness Recovery Action Planning (WRAP). Training will be provided first to Peer Counselors who have been certified to develop a cadre of trained trainers. Training will be offered to clients at least annually.
- Implement peer support and certify Peer Counselors.
- Expand information on and promote accessibility to SSA, Medicare and other community services that promote / support older adults in maintaining optimum function and meaningful activities.
- Expand peer counseling to support clients across the life span.
- Develop and implement concepts and programs that prioritize goals and outcomes that foster autonomy rather than maintenance and co-dependency.

Objective #2:

Involve clients and their family and caregiver advocates in all program design and planning of the recovery and resilience process.

Strategies:

- Increase the role of clients across the life span and families in quality management activities within MHD, state hospitals, RSN, CMHC, and CLIP via the Mental Health Planning and Advisory Committee.
- Continue to support the Consumer Roundtable**.**
- Showcase examples of client/caregiver involvement across the life span that demonstrate recovery, resiliency and reduction of stigma.
- Insist on client/caregiver presence across the life span on state hospital governing bodies and encourage presence on private hospitals governing boards, particularly where Medicaid money is utilized.
- Provide training to assist clients and caregivers to find their own voices and tell their own stories.
- Implement a culturally competent service delivery plan.
- Provide mentoring to clients and families prior to their membership on client/consumer committees and their attendance at stakeholder meetings.
- MHD will support client networking activities.

Objective #3:

Communicate with clients, and ensure the sustainability of the active involvement of clients and their advocate caregivers across the life span.

Strategies:

- Utilize the approved Consumer self-advocacy training & Executive Order project.
- Use clients and caregivers to assist with legislative proposals and as a tool to influence legislation that promotes recovery and resiliency

- Develop and train clients to work as mental health system advocates in order to expand committee membership expertise
- Publish and make available MHSIP survey reports in an easily understood manner.
- Develop, publish, and mail informational benefit brochure annually to clients. Identify in the document a way to communicate with the MHD directly to allow for feedback and comment.
- MHD staff meets directly with clients and caregivers through focus groups and/or attendance at meetings.
- MHD supports and receives information from clients' clubhouses to help programs to connect and share a common goal**.**
- The Office of Consumer Affairs (OCA) will develop an addition to the MHD's web page that is specific to adult clients containing frequently asked questions, definitions, resources, guides, etc.. Client Clubhouses and Consumer run programs will be added as a resource to the MHD's web page.
- Provide training to clients in use of MHD web site

Objective #4:

Respond to funding and infrastructure changes in the mental health system to sustain the goal of client driven services.

Strategies:

- Develop an independent Ombudsman program to support client driven services;
- Work with the Legislative Executive Mental Health Task Force to implement system change
- Develop and implement a plan to monitor and evaluate the impact of system changes on client care at the provider level
- Create workgroups to explore the programmatic and financial impact of changing the system structure.
    1. Examine current law and rule to Determine by survey or assessment revisions needed to change the system structure
    2. Conduct a risk management review of the system structure change
    3. Study the current continuum of care to identify community alternatives to residential, crisis and inpatient capacity needs.

Measures:

A. Determine by survey or assessment the number of clients who are informed of their right to have a mental health advance directive and increase that number by 20% each year until all clients are informed of their right to an advance directive.

B. Develop a program wherein clients' advance directives are protected by the state.
C. Require that all PIHPs have a mental health advance directive policy and procedures reflecting RCW 71.32
D. Determine by survey or assessment the percentage of clients reporting that they were allowed to direct their individual recovery and resilience planning and increase that number by 20% per year until the results show that each client is allowed to direct their individual recovery.
E. Determine by survey or assessment the percentage of clients reporting that providers respected their culture and increase that number by 20% per year until each client is respected.
F. Determine by survey or assessment the percentage of clients reporting they were treated with respect and increase that number by 20% per year until all clients are treated with respect.
G. Determine by survey or assessment the percentage of treatment plans that include either peer support or clubhouse activities and increase that number by 20% until each client is provided access to these recovery oriented treatment modalities.
H. Determine by survey or assessment the percentage of clients who are aware of their rights and the grievance process and increase that number by 20% each year until each client experiences support of their rights within the mental health system.
I. Determine by survey or assessment the percentage of clients along the life spectrum who could live in a lesser restrictive setting and at a level of optimal functioning and increase that number by 20% per year until each client is afforded the least restrictive environment.
J. Determine by survey or assessment the percentage of client records containing a treatment plan which was directed by the client and/or their representative caregiver or advocate and increase that number by 20% per year until all clients or their caregiver advocates are allowed to direct the needs of the client.
K. Determine by survey or assessment the number of MHD-sponsored skill building opportunities for clients including travel and expenses and increase that number by 20% each year until the unemployment rate of clients of the mental health system is comparable for general populations in the state.

C. IMPROVE ACCESSIBILITY AND SERVICE INTEGRATION – CUSTOMER PERSPECTIVE

Goal 3:

Persons with multiple-system needs receive integrated care, services are delivered in community settings wherever possible, and disparities in mental health services are eliminated.

Objective #1:

Increase coordination of agencies with clients with multiple treatment needs.

Strategies:

- For clients across all age spans, require through contract, that service protocols be implemented and followed with Children's Administration, Juvenile Rehabilitation Administration and Aging and Disability Services Administration.
- Develop a service protocol for clients across all age spans to provide them with one integrated plan of care.
- Review and address barriers identified through the development of service protocols and through RSN reports to the MHD on the progress of service protocol development within their service area.
- Determine by survey or assessment the need for wrap around services for clients across all life spans.

1. Identify RSNs with high percentage of need for wrap around services.
2. Require targeted RSNs to develop an action plan for these populations, to include ongoing monitoring and evaluation.
3. Require targeted RSNs to include this action plan in their Quality Improvement program.
4. Work in collaboration with RSNs to develop statewide wrap around services for populations requiring such services.

- Provide training on joint treatment plan requirements.
- Explore blended and braided funding options for integrated programs.

Objective #2:

Develop and improve formalized delivery agreements with other DSHS administrations and allied departments.

Strategies:

- Develop Memoranda of Understanding or working agreements to share with the field including requirements, confidentiality, documentation, filing, and budgeting.
- Clearly spell out in intra-agency and inter-agency agreements, including data sharing agreements, the expectation of each division and/or department working with multi-system consumers.
- Make staff aware of intra agency and inter agency agreements and ensure periodic review.
- Increase and improve discharge planning from inpatient settings for multi-system clients.
- Community Mental Health Agencies and RSNs participate in A-Teams and Families and Children Together projects.

- Expand cross-system care coordination efforts within DSHS including AADSA, DVR, MAA, DASA, DDD and with OSPI, DOC, and other relevant agencies.
- Require integrated treatment plans that focus on skill building, autonomy and decreased dependency on the publicly funded mental health system.

Objective #3:

- Develop and promote responsive crisis interventions that are recovery oriented with psychiatric hospitalization utilized only as a last resort.

Strategies:

- Using the Division's quality management infrastructure:
  1. Review crisis diversion (intervention) and involuntary treatment data for trends. Decrease involuntary commitment and increase community crisis responses that are timely and recovery oriented.
  2. Develop a decision package for Quality Council review and recommendations
  3. If appropriate, send recommendations to the Implementation and Design Group for the development and implementation of a quality improvement project.
- Using the Division's quality management infrastructure, evaluate the effectiveness of the CDMHP protocols.
  1. Review available data from the CDMHP protocol for trends
  2. Develop a decision package for Quality Council review and recommendations
  3. If appropriate, send recommendations to the Implementation and Design Group for the development and implementation of quality improvement projects.
  4. Expand the authority of CDMHPs to include assessment for benefits which would support community intervention, i.e. COPES, respite care, triage diversions from the criminal justice system, etc.

Objective #4:

- There is a continuum of care and improved access for both outpatient and inpatient services with the appropriate level of service provided to the client in the community as a priority.

Strategies:

- Support Parity initiatives for mental health care to reinforce its importance in overall health for clients across the life spectrum and cultural groups.
- Support legislative initiatives for mental health that promote recovery and resiliency and reduction of stigma.
- Reduce the use of adult state psychiatric hospitals, the children's state psychiatric hospital (Child Study and Treatment Center), and Children's Long Term Inpatient Programs (CLIP) by increasing community care modalities that provide comparable wrap around care.

- Provide clients across the life spectrum who are being discharged from the state hospitals with extensive community reintegration and resiliency supports to ensure the successful integration into the community and to decrease the likelihood of hospital readmission,
- Provide youth discharging from the state hospitals, CSTC, and CLIP facilities and their families/care providers with extensive community reintegration and resiliency supports to decrease the likelihood of hospital readmission
- Conduct a Needs Assessment of inpatient and diversion capacity (for all age groups) at the local level. Develop a plan to make needed resources available.
- Develop appropriate capacity for *a* flexible, integrated continuum of inpatient service, available regionally and statewide**.**
- Provide clearer definition of level of care for the entire continuum based on an underlying principle of treating persons experiencing mental illness with dignity and respect.
- Make quality mental health care very accessible and geared to recovery and resiliency.
- Continue to review Access to Care Standards for non-Medicaid clients with expanded capacity for skill utilization and building and promoting autonomy in order to foster less dependency upon the publically funded system of care.
- Develop a cultural appropriateness plan to insure that all mental health services are provided in an acceptable manner
- Develop continued care criteria for the state hospitals which include an awareness of the community life of the client and support the continuation of life in the community.
- Develop clear discharge criteria for the state hospitals which require written "acceptance of transfer of responsibility" by community providers thereby ensuring timely continuity of care.

Objective #5:

- There is a statewide utilization review process that includes a standard level of care for continuing stay and discharge criteria for outpatient mental health services.

Strategies:

- Using the Division's quality management infrastructure, :
    1. Review data for continuing care and discharge issue trends (Performance Data Group)
    2. Develop decision package for Quality Council's review and recommendations
    3. If appropriate, send recommendations for new criteria development to the Implementation and Design Group to develop and implement quality improvement projects.

Measures:

A. Determine by survey or assessment the number of clients who report recovery or improved functioning following use of mental health services and increase that number by 20% per year/
B. Determine by survey or assessment the number of clients who were removed from their homes or stable living arrangement to enter into the mental health system and decrease that number by 20% each year until the number of persons impacted are minimal and clients are treated within their communities.
C. Increase the use of EBPs for clients across the life spectrum.
D. Decrease the number of state hospital beds statewide where the social environment is operated under psychiatric supervision and increase the number of beds in the state which are operated on wards modeled after clubhouses by 20% each year until all detention facilities are recovery oriented.
E. Determine by survey or assessment the rate of use of physical, manual or chemical restraint and seclusion at Eastern State Hospital, Western State Hospital, and Child Study and Treatment Center and reduce the instances of use by 20% each year until completely eliminated.
F. Determine by survey or assessment the rate of use of physical, manual or chemical restraint and seclusion in CLIP facilities and reduce the instances of use by 20% each year until completely eliminated.
G. Increase the percentage of clients with COD diagnoses who receive COD treatment
H. Increase the number of adults with serious mental illness who receive supported employment services
I. Increase the number of adult clients who report they have timely access to mental health services
J. Increase/maintain the percentage of MH clients enrolled in WMIP who have an assigned medical primary care provider (PCP).
K. Determine by survey or assessment the percentage of clients who do not require inpatient services and increase the number by 20% until services are primarily community based.
L. Determine by survey or assessment the number of clients across the life span who are seen in the mental health system within 30 days following discharge from inpatient services and increase that number by 20% until every client is supported immediately after discharge from inpatient services.
M. Determine by survey or assessment the number of clients across the life span who report that they have timely access to mental health services and increase by 20% until most clients report they are receiving timely access to services.
N. Determine by survey or assessment the number of community diversion and crisis beds available in the state and increase the number by 20% each year with a decrease the percentage of crisis responses that lead to involuntary commitment.
O. Increase the number of Community Mental Health Agencies using one or more of the 16 identified EBPs
P. Determine by survey or assessment the percentage of older adults that report returning to or obtaining meaningful daily activities and increase that number by 20% each year until saturated.

Q. Determine by survey or assessment the number of persons from the mental health system referred to Vocational Rehabilitation and increase the number by 20% each year until all mental health clients are assisted by Vocational Rehabilitation.

D. IMPROVE PREVENTION AND CARE – INTERNAL PROCESS

Goal 4:

Early mental health screening, assessment, and referral to services are common practices for clients across life spectrums, ethnicity and culture.

Objective #1:
Promote the mental health of all citizens across life spectrums and ethnicity and cultures.

Strategies:

- Promote screening and early intervention in primary health care facilities and schools (e.g., EPSDT) thereby actively promoting the expectation of comparable decreases in instances of mental health crisis later in life.
- Provide screening for children and youth in potentially high-risk settings such as child welfare and juvenile justice settings
- Build on service coordination and collaboration developed as part of the Children's Mental Health Initiative (Children's Administration, Juvenile Rehabilitation, and Mental Health Division)
- Provide training for primary health providers to screen for and recognize early signs of emotional and behavioral problems, and to offer connections to appropriate interventions
- Provide information, support and treatment for parents who are experiencing mental health problems to allow them to better address the needs of their children.

Objective #2:
Improve and expand school mental health programs

Strategies:

- Collaborate with other state agencies serving children and their families to address the mental health needs of children and youth in the education system
- Develop a continuum of care to provide services and supports for children and youth in schools that includes training, prevention, early identification, early intervention, and treatment.
- Provide consistent State-level leadership and collaboration between education, general health, and mental health.

Objective #3:

Screen for co-occurring mental and substance abuse disorders and link with integrated treatment

Strategies:

- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the juvenile justice system
- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the child welfare system (such as children in foster care)
- Identify and initiate coverage for core components of evidence based collaborative care, to include a comprehensive range of treatment modalities, i.e. clubhouses, peer counseling, respite care, and supported employment.
- Involve clients and their caregiver advocates in program design and advocacy
- Investigate the use of blended and braided funding to provide integrated programming

Objective #4:

Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Strategies:

- Implement a collaborative care model with primary care providers and mental health providers
- Provide primary care access to specialized behavioral health screening services for individuals with special health care needs
- Identify and consider coverage for core components of evidence-based collaborative care, to include case management and disease management.
- Provide consultation to primary care providers by mental health specialists that do not involve face-to-face contact with clients
- Provide expanded Gatekeeper programming as an outreach to older or isolated individuals who may benefit from behavioral health screening
- Expand mental health services in all residential and community care settings.
- Implement a comprehensive screening process to promote early intervention and treatment for people with mental disorders, including dementia.

Measures:

A. Determine by survey or assessment the number of WMIP enrollees from primary care who are screened for behavioral health treatment (mental health and/or substance abuse) and increase that number by 20% per year.

B. Determine by survey or assessment the rate of referral for behavioral health screening for frequent users of medical care and increase that number by 20% per year.
C. Determine by survey or assessment the number of children and adolescents reporting improved school attendance after receiving mental health services and increase that number by 20% per year.
D. Determine by survey or assessment the number of children and adolescents reporting improved school performance after receiving mental health services and increase that number by 20% per year.
E. Determine by survey or assessment the number of older adults not receiving mental health services who require them and decrease that number by 20% each year until all older adults are properly served.

E. IMPROVE QUALITY ASSURANCE AND SUSTAINABILITY—INTERNAL PROCESS

Goal 5:

Improve data analysis in order to continuously improve mental health care services and accelerate research.

Objective #1: Implement Evidence Based Care statewide, and develop a common approach for the provision of mental health services for clients across the life spectrum using evidence based practices.

Strategies:

- Work with Mental Health Planning and Advisory Council on Evidence Based Practices (EBP) and promising practices to identify needs and barriers to EBP implementation. Develop clear funding streams and start up costs associated with each EBP.
- Develop requests for legislation to solicit on-going funding for EBPs not covered by Medicaid.
- Provide training and technical assistance and follow-up to sites implementing currently defined EBPs.
- Develop policies and monitoring strategies for EBPs (to include fidelity assessments, incentives, increased monitoring of consumer outcomes, process for incorporation of new EBPs).
- Develop reporting guidelines for EBPs.
- Showcase MH agencies with effective EBPs.
- Collaborate with other DSHS agencies to implement cross-system EBPs.
- Provide training, technical assistance for evaluation, and follow-up of new promising and innovative practices.
- Continue review of clinical practices, with inclusion of promising practices as they become supported by evaluation and consumer outcomes.
- Meet with SAFE-WA to dialog and receive input with regard to the best approaches for including families and youth in the provision of services

- Meet with Health Action to dialog and receive input with regard to the best approaches for including youth in the provision and development of services to youth
- Support the increased involvement of youth in system development
- Track the progress of joint strategies developed with other administrations and divisions.

Objective #2:
Increase dissemination and use of information throughout the mental health system.

Strategies:
- Increase access to information for all program, planning, fiscal and management personnel.
    1. Increase information dissemination throughout MHD headquarters with multiple short reports, decrease process and time-span for approval of reports.
    2. Create web-based, user-friendly report generating system that can provide standard reports or real-time queries of the MHD data.
    3. Train MHD staff on new report generating system, make available to all headquarter staff.

Objective #3:
Develop an information system that integrates quantitative and qualitative data across the mental health system and facilitates access to reports.

Strategies:
- Build on existing information systems to incorporate and integrate computerized data from Quality Assurance and Improvement reviews.
- Build on existing information systems to incorporate and integrate other qualitative data (e.g.; OCA, QA&I, Ombudsmen, and P&P).
- Better integrate information systems throughout DSHS to better identify older adults service needs for the development of more specific outcome measures.
- Integrate data from DVR to identify linkages that promote autonomy, skill utilization and building and decreased dependence upon the publicly funded system of care.

Objective #4:
Use performance indicator reporting to manage and improve the mental health system through contracts and quality improvement efforts.

Strategies:

- Develop Performance Indicators from the consumer outcome system.
- Develop Performance Indicators that are specific to older adults issues.
- Develop consensus within MHD about goals/benchmarks for these performance indicators.

1. Maintain involvement in national performance indicator efforts through CMHS, NASMHPD, ACMHA, NCQA, and JCAHO.

- Develop positive incentive system for RSNs following JLARC recommendations.
    1. Develop system to recognize programs/providers/RSNs that exceed expectations or demonstrate best practices.

Measures:

- Improve annual Self-Assessment survey ratings on "use of information for improvement" by MHD employees.
- Improve annual Self-Assessment ratings on "communication of organizational performance" by MHD employees.
- Improve MHD-wide Employee Survey scores on "work group access to data about the impact services have on clients"
- Improve MHD-wide Employee Survey scores on " use of data on the impact of services to improve services to future clients"
- Increase number of "fact sheets" or white papers produced by MHD.

E. IMPROVE WORKFORCE DEVELOPMENT AND DIVERSITY – INTERNAL PROCESS

Goal 6:

Business practices accommodate a changing environment, to include the use of technology to access mental health care and information.

Objective #1:

Use health technology and Tele-Health to improve access and coordination of mental health care, especially for clients in remote areas or in underserved populations

Strategies:

- Survey the mental health community for current uses of health technology and Tele-Health
- Continue to support RSN videoconferencing to enhance consumer and stakeholder meeting capabilities, Specialty consultations, and remote site access to care and services.
- Explore financial aspects of Tele-Health use, and coordinating traditional health and telehealth visits

Objective #2:

Develop and implement integrated electronic health record and personal health information systems**.**

Strategies:

- Survey the mental health community for current use of electronic health records and personal health information systems
- Continue to support the implementation of the integrated state hospital information system
- Continue to support the implementation of a person-centered, integrated, comprehensive electronic health record at all state facilities and community mental health agencies

Objective #3:
Provide employee training.

Strategies:

- One hundred percent of required training will be completed within required time lines. Activities:

1. Assign one staff to monitor, to track, and to report the status of individual employee training.
2. Ensure that individual training plans are created in connection with the employee evaluation process and with new employee procedures.

- Identify training opportunities on new federal requirements and ensure that at least one staff person attends.
- Identify training opportunities in information systems software and data retrieval methods.
- Offer at least one Quality Management and one best practices training to MHD staff.
- Invite allied systems to quality and best practices training and other educational opportunities.

Objective #4:
Implement an improved risk management program.

Strategies:

1. Ensure that the policy and procedures manual is up-to-date and revise as necessary.
    - Ensure that Department e-mail and Internet policies are communicated to and understood by Division staff.
2. Define scope of and conduct a risk management review of Division programs in order to identify risk mitigation activities that should be implemented.
    - Implement new federal regulations in a cost-effective manner, including BBA and HIPAA.
    - Maintain focus on improvements regarding work place safety at the state hospitals.
3. Continue to implement compliant billing practices at the state hospitals.

- Improve census tracking, utilization review processes, communication with the Finance Division, and planning for a new billing and collections system.

4. Offer training to RSNs and providers on consumer rights, and promoting the management of one's own care.
    - Address advanced directives for psychiatric care, dis-enrollment, and fair hearings.

Objective #5:
Improve project management.

Strategies:

- Conduct future planning to identify major projects and initiatives to be completed.
    - Develop a standard reporting mechanism to MHD management team for major projects.
    - Implement an improved policy on monitoring the progress of major projects.
    - Assign project staff to major projects and initiatives
    - Develop an All Hazards Disasters Response Plan with all disaster responders covered specific to mental health as their role is defined by DSHS.
    - Designate a program manager to a full time position dedicated administering and coordinating mental health activities associated with older adults.

Measures:

A. Increase the availability and use of health technology and telehealth within the mental health community
B. Increase the use of the electronic medical record technology within the community mental health agency
C. Fund and implement the electronic medical record initiative at state mental health hospitals.
D. Increase number of employees receiving required training
E. Increase the number of MHD-sponsored training opportunities for MHD staff
F. Increase number of MHD-sponsored training opportunities for providers
G. Increase number of MHD-sponsored training opportunities for consumers
H. Increase the number of older adults receiving mental health services.